# DÆDALUS

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## POLITICAL PHARMACOLOGY: THINKING ABOUT DRUGS

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# Political Pharmacology: Thinking About Drugs

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# Preface to the Issue "Political Pharmacology: Thinking About Drugs"

THE UNITED STATES, IN THE MIDST of what may yet prove to be the most bizarre of its twentieth-century presidential electoral campaigns, is officially at peace. The Cold War is over; no Korea, Vietnam, Iraq, Panama, or Grenada appears on the horizon to threaten any of America's purported vital interests. At home, the war idiom is muted; there is less talk of a "War on Drugs," though it is not always evident that it has in fact been won. There is no talk whatever of a "War on Poverty." That is yesterday's rhetoric, buried with two of the presidents of the 1960s, John F. Kennedy and Lyndon B. Johnson.

Precisely because the country is at peace—though few in Los Angeles or New York would choose to use that phrase, reserved mostly for those in Washington, D.C. who see it as a time of resilient democracy everywhere—this issue of *Dædalus* sets out to address a host of complex and delicate questions that politicians and others who pretend to candor but search for safety generally avoid. While the war on drugs is no longer touted in either federal government press releases or on prime-time television, the "drug problem"



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remains, linked to any number of conditions that make the United States truly "exceptional," though in ways few care to reflect on.

The country's *uniqueness* no longer resides in its prosperity. Among the civilized nations of the world it exists in the extraordinarily difficult relations between the races and certain ethnic groups, in the extent and range of the nation's impoverished classes, in the manifestly archaic quality of its criminal justice system, in the inadequacy of its public health and medical facilities for tens of millions of uninsured, in the burned-out and deserted slum areas of dozens of cities where public safety is unknown, in the bizarre conditions that exist in too many of the nation's elementary and secondary schools, that some pretend will be quickly remedied by something called "privatization." Schools for profit—a panacea not even considered by any other major industrial society that is democratic in more than name—is the new remedy for inadequate learning.

We live in a rhetorical age, made more so by the nature of the enthusiasms generated by the mass media. While the federal government pursues its efforts to halt the import of illicit drugs, claiming that the campaign is succeeding, the facts are otherwise. A debate that began in the 1960s, with some arguing for decriminalization as the way to "solve" the country's illicit drug problem, has passed into a quite different phase, explained and interpreted by many who have written for this special issue of *Dædalus*. For all sorts of reasons, and not only because of the increased prevalence of AIDS, a new emphasis is being given today to the inadequacy of America's medical and public health policies, of many of the institutions, public and private, designed to cope with the serious problems created by drug use, licit and illicit. While many millions depend today on tolerated drugs, including alcohol, not to speak of all the others available in any pharmacy, those are given less media attention than the supposedly more dangerous substances distributed on street corners in the segregated inner cities of the country, among those who are poor, black, and unemployed. The true nature of the "drug problem," and not only in the race-segregated urban centers of the country, is very rarely acknowledged; it is scarcely communicated by those who see an advantage in not confronting or admitting the complexities of the issue.

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Why do they look aside? Why, indeed, are they guilty of such massive oversimplification? Because the problem is too difficult. It is not susceptible to easy solution. It will not be resolved by the appointment of a new Drug Czar. Expenditure of new billions of dollars will not result in rapid and immediately observable improvement. It will not disappear when young children are taught in school to say "No." Indeed, it will not begin to be understood until attention is given to the specific political, social, economic, cultural, and intellectual forces at work in this society, that do so much to create hazardous family conditions, increasingly common, sustaining habits and practices that make drug use (and abuse) so prevalent. With drugs, as with so many of the other problems that confront the United States (and other advanced industrial countries) in the last decade of the century, the belief that "shame" will bring about reform, that conscience will translate into new and effective policy, is much too sanguine.

Certain facts are generally known. They do not by themselves cause millions to cast their ballots for change. Indeed, they do not generate any understanding of the kinds of change required. Many in the United States are aware that the prison population of this country is greater than that of any other civilized democracy in the world—well over a million Americans are today incarcerated in jail, more than two and a half million are outside, technically free, on parole and probation. Many know also that in both these categories a good number are young black males. The reactions to both these facts do not lead to a general outcry. There is no acknowledgment that the US criminal law system is a disgrace, recognized to be that by jurists and lawyers throughout the world. That situation did not suddenly arise because of a jury decision in Los Angeles in 1992. It has been developing for decades, and has been too rarely admitted.

To probe its gravity would be to look at all manner of complex institutions, the laws that Congress and the state legislatures have passed, and not only in respect to drugs; the court systems that exist on the local, state, and federal level; the prisons being built in such number today, even in states led by so-called "liberal" governors, responding to intense public pressure; the education provided inmates, and not only to prevent recidivism; the men and women employed in penal institutions; the police forces more generally. It would oblige the country to look in new ways at its poverty, its

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unspeakable slums, sanitized in modern parlance as the country's "inner cities." There is a need to ask why wholly destroyed nations like Germany and Japan, with huge pockets of poverty before World War II, were able to eradicate such blight, why any number of other societies, even more poor, are today rich, showing few of the social and moral inadequacies that are so casually accepted by so many in the United States.

The tendency to blame the victims, imagining that it is their indolence and "sinfulness" alone that creates the country's social problems is to ignore what many know to be true—*family policy,* traditional in other advanced societies, generally first perceived by so-called "intellectuals" and then implemented by a responsible political class, requires wide community consent. Unless there is a general understanding of why many stand to gain from a change in attitudes and programs, no safety net against the specific ravages common to industrial societies will ever be provided.

Other free societies, confronted with problems comparable to those that exist in the United States today—poverty, violence, lawlessness—have at various times in their history been willing to cope with them in imaginative and novel ways. They have known that reform presupposes intelligence, that it must be based on a willingness to discard antiquated remedies. It cannot be grounded in a pretended and expense-free tolerance, even less in outmoded forms of repression, coated in moralistic rhetoric. Reform generally calls for active engagement, not only by those who preen themselves on being "enlightened," but also by those not inclined to disdain the "values of the heart"; it involves the building of complicated political alliances between the intellectually motivated and those who are proud of their humanitarian impulses, linked very often to a great variety of secular or religious principles.

Edmund Burke, as early as the eighteenth century, spoke of that revolutionary epoch as an "age of calculators," where material interests and concerns were made to seem all-important. Twentieth-century technology, quite as much as the growing passion for consumption, guarantees that an economic order in difficulty or decline will generate demands for change. In these circumstances, there is always an occasion for rhetoric, not least by those who belong to the political class. It is not enough, however, to preach corporate, community, and individual responsibility; these are mere

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words, increasingly abstract and irrelevant. They are substantially less concrete than those that acknowledge the existence of "interests," the life-blood of a democratic order. No one of them can be entirely ignored, if genuine as distinct from superficial reform is attempted, if fear is to be significantly abated.

The title of this issue, "Political Pharmacology: Thinking About Drugs," is itself a calculated one. Politics is at the center of America's drug problem. It is impossible to conceive policies for dealing with it if one fails to recognize that the White House today is not what it was in the time of Dwight Eisenhower, that Congress is not just panting for someone to arrive with a vast new program, to be enacted in one hundred days. The country is not what it was at the end of World War II. The relations between the races are not what they were. The cities are parched deserts, unlike those of a prosperous and self-confident Europe, not to speak of a nascent and bustling Asia. The skyscraper centers of the "new South," but also of so many other regions of the country, empty after business hours, do not begin to provide the solace or release that cities were intended to give. Nor, for that matter, do they obliterate the desolation of slum life, violent and dangerous principally to their inhabitants, but also to others. In such an American world, opinion cannot be what it was at another time of crisis, during the worst days of the Great Depression, for example.

This issue of *Dædalus* is about drugs, licit and illicit. It is also about crime and punishment, themes that have dominated the thinking of other civilized and progressive societies. It is about health and well-being, matters that must concern individuals and communities who understand the importance of public policy in shaping social and economic life. It is about history—that of the United States and others—but also about culture, our own, that of the modern world, that of many subterranean social worlds too often ignored or scorned. In short, it is an issue devoted to the theme of complexity, to the proposition that a new war on drugs will not be won in four months or four years, that "war" is in any case the wrong metaphor, to be avoided. Such inflated political rhetoric, a substitute for reflection, study, and the allocation of true resources, is intended principally to shape and sway public opinion. It will sometimes serve to win votes; it can never resolve intractable problems.

This is the second occasion when Global Pursuits, Inc., whose advisory board members are W. Daniel Hillis, Daniel Kleitman,

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N. Metropolis, Gian-Carlo Rota, Jaqui Safra, Michael S. Waterman, and Karl-Heinz Winkler have helped us with funding. We feel a very great indebtedness to them for making this issue possible. "Political Pharmacology: Thinking About Drugs" treats more sensitive matters than any considered in "A New Era in Computation," also supported by Global Pursuits. The Editor, encouraged to believe that a spirited issue was the only sort that made sense in the present situation, looked for concrete recommendations. It is to be hoped that readers will agree that such have been provided, that every effort has been made to include contributions from men and women of different views, who understand the complexity of the situation, who propose novel remedies, knowing that posing certain questions may be the first requirement for dealing with a complex and politically charged matter.

S.R.G.

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*Mathea Falco*

# Foreign Drugs, Foreign Wars

FOR MUCH OF THIS CENTURY, Americans have believed that foreigners are chiefly to blame for the nation's drug problems. Since the Harrison Narcotic Act of 1914, which outlawed heroin and cocaine, drug policy has concentrated primarily on reducing supplies of illicit drugs through law enforcement, interdiction, and eradication in drug-producing countries. This supply-side approach assumes that curtailing drug availability will drive up prices, forcing American drug users to stop or to seek treatment. In this view, increased prices also deter new users from trying drugs. Unfortunately, supply control initiatives have failed to reduce drug addiction and drug crime in the United States, while costing American taxpayers more than $100 billion in the past decade alone.[1] In the century-long war against drugs, it is finally time to wage the battle at home.

## ILLICIT DRUGS—A FOREIGN THREAT

The drugs of greatest concern to Americans—heroin, cocaine, and marijuana—mostly come from abroad. When they were first prohibited, these drugs were associated in the public mind with immigrant groups and racial minorities who were feared as potentially violent and subversive.[2] Opium was identified with Chinese laborers in the West; cocaine with blacks, particularly in the South; marijuana with Mexican immigrants in the Southwest. These alleged links between foreigners and drugs prompted the US government to use diplomacy, threats, money and even military force to prevent drugs from coming

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into the country. In 1909, the United States took a leading role in convening the Shanghai Opium Commission, the first international meeting to discuss the flourishing worldwide opium trade. Next came the Hague Opium Convention of 1912, which pledged nations to restrict opium production. Inspired by commercial interests seeking to expand trade with China (which had adopted strict anti-opium laws in 1906), Washington also wanted to cut off opium traffic into the Philippines, acquired in the Spanish-American War in 1898. These early commitments to international action established a pattern for American policy that survives to this day: tough international measures to destroy drugs at their foreign source would effectively curtail domestic drug abuse. In subsequent treaties, the United States has pledged to control psychoactive pharmaceutical drugs as well as heroin, cocaine, and marijuana, and to cooperate on international law enforcement against major trafficking networks.[3]

When illegal drug use became widespread in the United States in the mid-1960s, the government responded by stepping up international drug control efforts. In 1969, President Nixon's Operation Intercept closed a key crossing on the US-Mexican border for three weeks in order to pressure the Mexican government into taking action against heroin and marijuana production. Turkey—the first link of the famous "French Connection"—was also the target of American protests. One US Senator publicly threatened to bomb Istanbul if Turkish opium producers continued to supply the heroin traffickers. During the next decade, cooperative programs with Mexico and Turkey, which cost Americans about $150 million, succeeded in reducing the flow of heroin from those countries into the United States. By 1980, Turkey was no longer a source for the international heroin traffic, and Mexico's share of the US heroin market had fallen from 90 percent to 25 percent. During the late 1970s, heroin addiction also declined from an estimated 550,000 to 400,000 addicts.

But the impact was short-lived as other producers in Southeast Asia's Golden Triangle (Laos, Burma, and Thailand) and South Asia's Golden Crescent (Afghanistan, Pakistan, and Iran) quickly increased production to satisfy American demand, and traffickers established new networks. By 1982, heroin was once again readily available in the United States.

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During the same period, the Mexican campaign against marijuana succeeded in cutting Mexico's share of the American marijuana market from 95 percent to 10 percent. Paradoxically, the campaign also stimulated illicit marijuana cultivation within the United States. By the late 1970s, marijuana had become the largest cash crop in California, Hawaii, and Oregon. Production in Jamaica and Colombia soon replaced Mexican supplies, but with marijuana that was more potent and more expensive, increasing health hazards for users as well as profits for traffickers. When the US government urged Colombia to use herbicides to eradicate its marijuana fields in 1981, Bogota newspapers observed that Americans were trying to protect their own fledgling marijuana industry. In fact, American efforts to curtail foreign supplies succeeded only in shifting sources, not in reducing drug abuse.[4]

## THE 1980s WAR AGAINST COCAINE

Promising to conquer the "evil scourge" of drug abuse in his first inaugural address in 1981, President Ronald Reagan gave unprecedented importance to supply control efforts. In a radical shift from the policy of earlier Republican and Democratic administrations which had stressed demand reduction efforts, Reagan allocated 80 percent of the nation's antidrug budget to law enforcement and interdiction. From 1981 through 1986, funding for drug law enforcement more than doubled—from $800 million in 1981 to $1.9 billion in 1986—while funding for prevention, education, and treatment declined from $404 million to $340 million.[5]

Reagan believed America's drug problems stemmed from an overly tolerant approach toward drug users, drug dealers, and drug producing countries. Colombia, the source of almost all the world's refined cocaine, became the main focus of US policy, followed by Peru and Bolivia, where most of the raw material, coca leaf, is grown. However, the supply control policies which briefly reduced American heroin imports in the 1970s had little effect on the burgeoning cocaine traffic.

Several critical factors that shaped the earlier efforts were absent in the cocaine source countries. Unlike Turkey and Mexico in the 1970s, Peru and Bolivia in the 1980s lacked strong governments in control of the growing areas, where coca was a traditional crop, used

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for centuries as a mild stimulant. In Colombia, the drug cartels secured local political support through bribes, threats, and charitable activities and were protected by forces better equipped than the Colombian army or national police. In all three Andean countries, the exploding American demand for cocaine generated billions of dollars of profit for traffickers and steady income for previously impoverished farmers. Drug eradication on the Mexican model was thus fiercely resisted, including by force, in the rural areas of Peru and Bolivia. Wherever local police intervened to burn coca plants, the growers opened larger fields in more remote, previously uncultivated areas. The eradication effort was also complicated by the failure to develop an effective herbicide which was ecologically safe. Thus, coca production expanded rapidly, tripling between 1981 and 1988, while wholesale cocaine prices in the United States fell from $60,000 to $12,000 a kilo.[6] Meanwhile, cocaine use soared; 25 million Americans admitted using the drug at least once in 1988, compared to 12 million in 1985.[7]

At the same time, the Reagan administration launched the largest drug interdiction campaign in the nation's history, intended to seal the borders against the drug traffic, particularly at key entry points. Beginning in 1982, Vice President George Bush chaired the South Florida Task Force of the National Narcotic Border Interdiction System, which included hundreds of officials from the Coast Guard, Customs Service, Drug Enforcement Administration, and Justice and Treasury Departments. But despite massive spending increases, the General Accounting Office (GAO) found in 1983 that more drugs were entering the country than five years earlier and that only 10 percent of the traffic was being intercepted. In 1985, another GAO study reported similarly discouraging results.

As part of its "get tough" supply-side approach, the Reagan administration upgraded interdiction efforts against marijuana. (Earlier administrations had given higher enforcement priority to heroin and cocaine, on the grounds that they presented greater health dangers than marijuana.) This strategy backfired, unintentionally encouraging many traffickers to switch to cocaine, a far more profitable and difficult target of interdiction than the bulkier marijuana. Cocaine prices fell precipitously, and the stage was set for the development of crack, a breakthrough that created vastly greater demand and multiplied cocaine profits for street-level dealers.[8] Cheap

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and readily available, crack produced more rapid, more intense euphoria than cocaine. By 1986, the crack epidemic was sweeping across the country.

The Reagan Administration's vigorous attack on marijuana smuggling further stimulated marijuana cultivation within the United States. By 1987, the National Narcotics Intelligence Coordinating Committee estimated that domestic production supplied as much as one-quarter of the market compared to less than 5 percent in 1980. Assessing the impact of the interdiction campaign in 1988, the Rand Corporation concluded, "It may turn out, unfortunately, that the United States has at last managed (rather expensively) to provide effective tariff protection for one industry: marijuana production."[9]

## THE BUSH DRUG WARS—MORE OF THE SAME

President George Bush has pursued the policy directions set by his predecessor, concentrating on law enforcement, interdiction, and foreign initiatives to prevent drugs from entering the country. Demand reduction efforts remain a low priority, with prevention, education, and treatment programs receiving less than 30 percent of total federal antidrug funds. Meanwhile, funding for the war on drugs has gone from $4.5 billion in 1988 to $12 billion in 1992. During the same period, US international control and interdiction programs have jumped from $1 billion to $3 billion. (see *Figure 1*)

As the Cold War came to an end, the Bush Administration cast about for new missions for the US military. Not surprisingly, fighting drugs emerged as a prime candidate. In February 1990, President Bush called for increased military resources to deal with "new threats beyond the traditional East-West antagonism of the last 45 years . . . Narcogangsters concern us all, already a threat to our national health and spirit . . . They must be dealt with by our military in the air, on the land, and on the seas." Military spending for drug interdiction now stands at $1.27 billion compared to $5 million in 1982.[10]

Despite these massive outlays, the flow of drugs into the United States has not abated, and worldwide production continues to increase.[11] The General Accounting Office reported in 1991 that drug imports have not declined and that American officials are seizing no more than 1 percent of the total. A kilo of cocaine costs $15,000, only one-quarter of its 1981 price, while heroin prices are at historic

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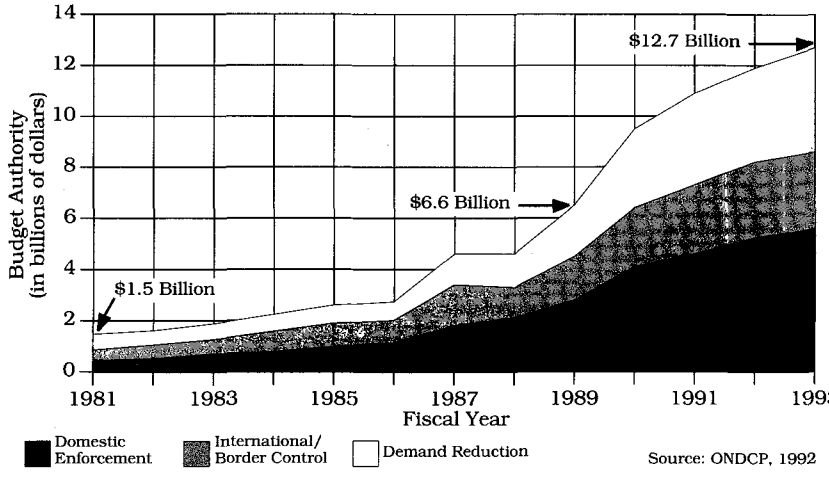
Figure 1. National Drug Control Budget, 1981–1993




lows. In some cities, a vial of crack now costs less than a single admission to the movies, well within the reach of most teenagers.[12]

By the traditional measures of success—increased drug prices and reduced drug availability in the streets of our cities—the supply-side approach has not worked. But these policies have also contributed to political instability in countries where government control is increasingly fragile. By supporting police and military antidrug operations abroad, our efforts often exacerbate human rights abuses and corruption among government officials we have enlisted to fight our drug wars.

Peru offers the most current example of the sometimes perverse impact of US narcotics control assistance. President Alberto Fujimori, who was democratically elected in 1990, dissolved the government and parliament and called in the military in April 1992, which he explained was necessary in order to combat the Shining Path (Sendero Luminoso) insurgency. Yet, for ten years, the United States had unwittingly encouraged the growth of the Shining Path by supporting crop eradication and police raids in rural areas where coca is the principal source of income. The Shining Path benefited from the anticoca campaign, recruiting new members from disgruntled farmers as well as offering protection for a price. At the same time, thousands of Peruvian officials also profited by protecting the

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traffickers, which caused the United States to suspend narcotics assistance in November 1991. After a brief resumption, aid was again cut off following the military takeover. Peruvian coca production has more than doubled since 1985.

In December 1989, President Bush justified the invasion of Panama and the seizure of General Manuel Noriega as an important victory in America's drug war. "Operation Just Cause," as it was known, cost several hundred million dollars and dozens of American and hundreds of Panamanian lives. Extensively damaged during the invasion and by the subsequent loss of investor confidence, the Panamanian economy is still struggling to recover its earlier momentum. The Panamanian people and the American taxpayer have paid a very high price for getting rid of Noriega. Meanwhile, the Drug Enforcement Administration reports that cocaine traffic from Panama has increased substantially from the levels of the Noriega period.

## WHY FOREIGN DRUG WARS FAIL

Our recent history has shown that international programs to cut drugs off as close to their source as possible usually do not work. The only near successes—Turkish and Mexican efforts to curtail opium production in the 1970s—were short-lived because other producers stepped in to satisfy American demand. In the case of the cocaine countries, we have not enjoyed even a brief victory. The strategy is fatally flawed.

The overriding goal of interdiction and source country programs is to drive up drug prices for American consumers. Yet, the largest profits from the drug traffic are made at the street level, not in foreign poppy or coca fields, or on the high seas. Because of this price structure, breaking up street drug markets is more effective than massive interdiction efforts in making drugs expensive and difficult to find. The active presence of police officers in drug-infested neighborhoods increases the "hassle" factor that drug dealers and buyers face. Even if drug prices remain unchanged, increasing search time to make a deal can reduce drug abuse.[13]

The total cost of cultivating, refining, and smuggling cocaine to the United States accounts for less than 12 percent of the retail price in the nation's cities. Even if the United States was able to seize half the

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FIGURE 2. Cocaine Prices Through The Distribution Chain, 1988
(Per pure kilogram equivalent)

| | |
|---|---|
| At the farm | $ 750 |
| Export (Colombia) | $ 2,000 |
| Import (Miami) | $ 15,000 |
| Wholesale (1 kilogram in Detroit) | $ 23,000 |
| Ounce (Detroit) | $ 47,000 |
| Retail (1-gram units) | $135,000 |

Source: US Department of Justice, Drug Enforcement Administration.

cocaine coming from South America—a wildly optimistic prospect—cocaine prices in American cities would increase by little more than 5 percent. Since prices are already so low, such increases would not affect consumption. (see *Figure 2*)

Moreover, a relatively small volume of drugs can supply our entire drug market. A twenty square mile field of opium poppies produces enough heroin to meet annual American demand. Four Boeing 747 cargo planes or thirteen trailer trucks can supply American cocaine consumption for a year.[14] Even if the governments of Peru and Bolivia were able to curtail cocaine production—which is highly unlikely given current economic and political conditions—neighboring Andean countries could rapidly replace these sources. Indeed, coca cultivation has already expanded into Brazil, Colombia, and Ecuador.

Although there is no shortage of opium, production continues to increase in countries which have few economic alternatives. The recently independent Central Asian Republics, particularly Khyrghizistan and Kazakhstan, are emerging as new sources now that Soviet rule has ended. In Burma, the military dictatorship, pressed for hard currency and isolated from world markets, relies on opium profits to support its war against dissident groups. Since 1988, Burmese opium production has almost doubled, far surpassing the total production of all other countries combined.[15]

## PROGRESS AT HOME

What progress has been made in combating drug abuse in the United States comes from reduced demand, not reduced supply. The substantial declines in marijuana and cocaine use in recent years,

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particularly among better educated Americans, reflect the power of health concerns and negative social attitudes towards drugs. But while occasional drug use has declined, drug addiction has not. In 1991, the Office of National Drug Control Policy (ONDCP) estimated that there were at least 1.8 million "hard-core" cocaine addicts, three times as many as estimated several years earlier. In addition, ONDCP reported an increase in heroin addiction, with 600,000 to 700,000 addicts. The Institute of Medicine estimates that 5.5 million Americans have serious drug problems that require treatment. Meanwhile, the numbers of Americans who acknowledge using cocaine at least once a week have increased along with hospital reports of cocaine and heroin overdose cases. The nation's drug epidemic is far from over.[16]

After decades of blaming other countries for domestic drug abuse, Americans should recognize that the problems and solutions lie here at home. We have learned a great deal about reducing drug abuse and drug crime in recent years, but we have not yet begun to apply what we know on a national scale. America's primary antidrug strategy must be to reduce demand, through new approaches to prevention, education, treatment, and community law enforcement.

## TOWARD A NEW INTERNATIONAL STRATEGY

There is still good reason for the United States to support international drug control cooperation, although we can do so less expensively and more effectively. However, bilateral programs should no longer be the centerpiece of policy. Instead, the United States should support multilateral initiatives through the United Nations and regional groups, like the Association of Southeast Asian Nations and the Organization of American States. Reducing worldwide illicit drug trafficking will require global efforts, and US funding for multilateral programs has been minimal. The average US contribution to the UN drug agencies has remained under $5 million a year since 1977. In the past, management problems with these agencies jeopardized US support, but a recent reorganization holds promise that the UN will play a more vigorous role in the future.[17]

In many ways, the United Nations can work more effectively with drug source countries than the United States. World opinion and resources channeled through the United Nations often have more

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impact than bilateral pressure because they are more politically acceptable. American narcotics control programs operating abroad often raise sensitive issues of national sovereignty, particularly when law enforcement is involved. For example, "Operation Blastfurnace," a Bolivian-US campaign against cocaine labs in 1986 in which US military personnel and DEA agents actively participated, generated so much local opposition that it has never been repeated. Instead, special UN enforcement teams could assist governments which ask for help in attacking the traffic, in much the same way as UN peacekeeping forces now work to end civil strife in Yugoslavia and Cambodia.

The United Nations could also provide support for source country eradication and crop replacement programs. When the Turkish government outlawed the cultivation of opium in 1972 in response to US pressure, the United Nations helped establish alternative employment for Turkish poppy farmers. Although the $30 million program was funded by the United States, Americans did not direct its implementation. Nonetheless, political opposition to the opium ban brought down the Turkish government in 1974, and the successor regime reinstated limited, highly controlled opium cultivation for the international pharmaceutical market. Since then, the United Nations has closely monitored Turkish opium production, which has not reemerged as a source for the illicit traffic.

Under the UN umbrella, the United States should take the lead in going after the multinational financial organizations which support the drug traffic. The 1988 Convention Against Illicit Traffic establishes a framework for attacking money laundering and bank secrecy worldwide. It provides for the seizure of assets, extradition of traffickers, and transfer of criminal proceedings. For the first time, the international community has agreed to work together to undermine the traffic profit structure, even though such efforts might expose corruption in major institutions. As with source country programs which also raise national sensitivities, the chances for effective action may be greater through the United Nations.

Foreign cooperation is enhanced when producing countries have strong reasons of their own for undertaking narcotic control programs. In the 1970s, the Mexican government was motivated to eradicate drug cultivation in order to gain control over the remote growing areas in the Sierra Madre mountains. Similarly, the Colom-

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bian government, faced with a separatist Indian movement in the Guajira peninsula, agreed to an eradication campaign against marijuana in the 1980s because drugs helped finance the opposition.

Producer countries are finding that expanding drug production encourages local drug abuse. Worldwide drug production vastly outstrips American consumption. International traffickers are flooding Western European countries, where users pay top prices for heroin and cocaine. Drug epidemics have also developed in Latin America countries, where less expensive drugs, like smokeable coca paste (basuco), are popular.[18] The major opium producing countries have large numbers of addicts: Iran has more than one million; Pakistan, about half a million, and Thailand, three hundred thousand. At the local level, crop eradication and disruption of drug refining can be effective in driving up drug prices. For this reason, governments trying to reduce domestic drug abuse should be able to turn to the United Nations for assistance in curtailing illicit cultivation.

However, even with a strong UN drug effort, it will take decades to make meaningful inroads into global drug production. Attacking demand internationally as well as domestically must be our first priority, since consumption fuels the market. Drug abuse is now a worldwide epidemic, afflicting even the People's Republic of China and the former Soviet Union, whose Communist governments prided themselves on being free of this form of Western decadence. In the United States, which has the longest history of drug abuse, demand reduction programs are not yet widespread enough, but we are well ahead of most other nations in this regard. Here again, the United Nations, with the United States playing a central role, could bring knowledge and policy together for the international community.

As part of its larger foreign policy objectives, the United States should, of course, support economic growth in countries which rely on drug production. Foreign assistance, if no longer directed at drug eradication, can still encourage democracy and economic development. Heavy debt burdens and chronic poverty are corroding government stability in many drug-producing countries in Latin America and Asia. But the United States has never integrated its concerns about narcotics control into a broader assistance strategy, especially when domestic commercial interests are at stake. For example, the United States provided Colombia $85 million in narcotics assistance

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in 1990 to combat its estimated $2 billion in cocaine exports, but largely ignored Colombia's continued requests for lower tariffs on its principal legal exports—coffee and cut flowers. As the Colombian government has repeatedly pointed out, unless Americans open their markets to legitimate products, many countries will have no choice but to rely on the illicit traffic for hard currency earnings.

What the United States can do to reduce domestic drug abuse has little relation to actions taken beyond our borders. Still, the failure of international supply-side efforts should not cause the United States to turn its back on the many drug-producing and consuming countries which share our concerns. We now know how to work with them more productively through international organizations on reducing incentives for producers, worldwide law enforcement against traffickers, and new education and treatment initiatives. But the core of our drug problem is at home. It is only here that we will find lasting answers.

ENDNOTES

[1]This estimate is based on a Rand Corporation calculation of total drug enforcement expenditures for 1989, which found that state and local governments spent slightly more than twice as much as the federal government. Federal drug enforcement spending amounted to about $35 billion from 1981 to 1992. Assuming the Rand ratio provides a reasonable measure, total federal, state, and local drug enforcement spending for the period would have exceeded $100 billion.

[2]David F. Musto, *The American Disease: Origins of Narcotics Control,* expanded edition (New York: Oxford University Press, 1987). See also David Musto, "Opium, Cocaine, and Marijuana in American History," *Scientific American* (July 1991): 40–47 for an excellent, brief overview.

[3]The three major international treaties are the 1961 Convention on Narcotic Drugs, the 1972 Convention on Psychotropic Substances, and the 1988 Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances. For description of these treaties, see *Compilation of Narcotics Laws, Treaties, and Executive Documents,* Report for The Committee on Foreign Affairs, US House of Representatives, Congressional Research Service, Library of Congress (Washington, D.C.: June 1986), and *National Drug Control Strategy,* The White House (Washington, D.C.: September 1989).

[4]For a review of federal drug policy from 1968 to 1988, see Mathea Falco, *Winning the Drug War: A National Strategy* (New York: Priority Press Publications, Twentieth Century Fund, 1989).

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[5]Figures provided in the President's 1988 Budget request were prepared by the National Drug Enforcement Policy Board, Department of Justice, Washington, D.C.

[6]For a thorough discussion of Latin American cocaine production and profits, see Peter Andreas, Eva Bertram, Moris Blachman, and Kenneth Sharpe, "Dead-End Drug Wars," *Foreign Policy* 85 (Winter 1991–1992): 106–28, and Bruce M. Bagley, "Colombia and the War on Drugs," *Foreign Affairs* 67 (1) (Fall 1988): 70–92.

[7]Data on illegal drug use come from the *National Household Survey on Drug Abuse* (Rockville, Md.: National Institute on Drug Abuse, 1985 and 1988). The survey, which is now conducted annually, is based on interviews of Americans age twelve and older who are living in households. Since it does not include people who are transient, homeless, in jails or other institutions, the survey probably underestimates drug use among certain groups.

[8]One ounce of cocaine, which costs about $1,600 on the street, can be converted (by cooking for a few hours with baking soda) into 400 vials of crack which will sell for $2,500 or more. These profit margins have attracted greater numbers of people into low-level dealing.

[9]Peter Reuter, Gordon Crawford, and Jonathan Cave, *Sealing the Borders: The Effects of Increased Military Participation in Drug Interdiction* (Santa Monica, Calif.: Rand Corporation, 1988).

[10]Ibid., and *National Drug Control Strategy,* The White House (Washington, D.C.: January 1992).

[11]See US Department of State, Bureau of International Narcotics Matters, *International Narcotics Control Strategy Report,* March 1992, for a detailed analysis of worldwide illicit drug production and trafficking. The report estimates that since 1988, coca production has increased 12 percent and opium production 25 percent.

[12]The price of marijuana has risen slightly, reflecting reductions in domestic availability because of intensive eradication campaigns aimed at American growers. The shortfall in supplies has not yet been replaced by foreign imports. For a thorough examination of supply-side failures, see Peter Reuter, "The Limits and Consequences of US Foreign Drug Control Efforts," in Eric D. Wish, ed., *Drug Abuse: Linking Policy and Research, Annals of the American Academy of Political and Social Science* (521) (May 1992): 151–62.

[13]Mark A.R. Kleiman and Kerry D. Smith, "State and Local Drug Enforcement: In Search of a Strategy," in Michael Tonry and James Q. Wilson, eds., *Drugs and Crime* (Chicago: University of Chicago Press, 1990).

[14]Leslie H. Gelb, "Yet Another Summit," *New York Times,* 3 November 1991.

[15]In 1991, Burma produced 2,400 metric tons of opium compared to a total of 1,500 tons from Laos, Thailand, Afghanistan, Iran, and Pakistan. US Department of State, *International Narcotics Control Strategy Report,* March 1992.

[16]The Drug Abuse Warning Network (DAWN), which monitors emergency room episodes and medical examiner reports involving illegal drugs, reported 10 percent increases in cocaine and heroin overdoses nationwide in the second and

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third quarters of 1991—the most recent data available. For estimates of treatment needs, see Dean R. Gerstein and Hendrick J. Harwood, eds., *Treating Drug Problems: A Study of the Evolution, Effectiveness, and Financing of Public and Private Drug Treatment Systems,* Institute of Medicine (Washington, D.C.: National Academy Press, 1990).

[17]For an encouraging overview of possible multilateral initiatives, see Jeffrey Laurenti, ed., "The Global Connection," *A Report of the Global Policy Project,* (New York: United Nations Association of the USA, 1991).

[18]For a comprehensive discussion of Latin American drug problems and US policy, see "Seizing Opportunities," *Report of the Inter-American Commission on Drug Policy* (San Diego: Institute of the Americas, University of California, June 1991).

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*Peter Reuter*

# Hawks Ascendant: The Punitive Trend of American Drug Policy

DRUG POLICY HAS GENERATED TWO DEBATES. The more elevated one concerns the retention of our current prohibitions, the legalization debate. Though it has occasionally impinged on the rhetoric of political discussion, as in the attack against legalization in the introduction to the first *National Drug Strategy,* this debate remains largely a parlor sport for intellectuals, divorced from the policy-making process. The more consequential, albeit less lofty, debate has been that between what are usually called the supply-side advocates and the demand-side advocates. The supply-siders, with former National Drug Control Director William Bennett as their most articulate spokesman, seek continued expansion of the nation's effort to imprison drug sellers and detect and punish (in various ways) drug users, while denying that they are slighting demand-side considerations.[1] The demand-side advocates, led by Senator Joseph Biden, while generally accepting the need for "vigorous enforcement," argue that current resource commitments to programs directly aimed at demand (prevention and treatment) are grossly underfunded and should be massively increased, even if this is at the expense of enforcement.[2]

Neither debate is satisfactory. The legalization debate is too focused on extremes, excluding the possibility of compromise. It is strident, with both sides casting aspersion on the values of the other. On the other hand, the debate between the supply and demand-siders is too narrow, allowing only minor programmatic tinkering.

Borrowing liberally from the classic essay of Nye, Allison, and Carnesale on approaches to preventing nuclear war,[3] I propose to

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combine the two debates on drug policy into a three-sided discussion among hawks (supply-side advocates), doves (legalizers), and owls (bold demand-side advocates) about the nature of the drug problem and the consequences of different approaches to controlling it.[4]

Drug policy debates have been conducted largely in terms of images. The hawks point to the immediacy of the problems in the streets (particularly the carnage surrounding drug distribution) and reasonably (though in intemperate tones) ask whether efforts at drug prevention or treatment offer any reasonable hope for controlling those markets and associated violence in the near future. They note the apparently low success rates of drug treatment programs; many programs show relapse rates of more than 60 percent.[5] Prevention programs aimed at seventh graders (the most commonly targeted grade) will reduce the number of adult drug addicts only with a five to ten year lag. Finally, they argue that effective prevention and treatment require intense enforcement, both to make drugs difficult to obtain (driving users into treatment) and to make drug use appear legally risky (reinforcing prevention messages).[6]

The doves' message is even clearer than that of the hawks. After defending themselves from the charge that they condone the use of drugs by asserting that society should strive to reduce use of all dangerous psychoactive drugs[7] including alcohol and cigarettes, they go on to argue that most of the current evils associated with drugs arise from the prohibitions and enforcement of those prohibitions. The violence, overdoses, and massive illegal incomes that are such a prominent part of our current concerns with psychoactive drugs are not consequences of the nature of the drugs themselves but rather of the conditions of use that society has created. Doves are strong on critiques of the current regime[8] but rather weak in describing their preferred alternatives. However, they are clear that criminal prohibitions should play no role in society's efforts to keep use of psychoactive drugs to a minimum.[9]

The current owls are less eloquent. They argue that drug enforcement has proven a failure. The intensification of enforcement throughout the 1980s failed to stem a massive growth in the nation's drug problems. Enforcement does not go to the root of the problem; with a loss of faith in source country control programs (such as crop eradication and crop substitution),[10] the root of the problem is now seen to be the initiation of new users in the United States and the

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failure to provide good quality treatment for addicts. Prevention and treatment receive a derisory share of what the nation spends to control its drug problems. Public treatment programs, faced with the most difficult clients, have far fewer resources to spend on those clients than do private treatment programs.[11] Success in reducing the nation's drug problem requires a change in spending priorities. *Sotto voce,* at most, they also suggest that intense drug enforcement increases crime and may exacerbate health problems related to drug use; however, they believe in the value of the criminal prohibition and significant enforcement against drug dealers.

This essay has two goals. The first is to describe the increasing success of the hawks. To an extraordinary degree, they have taken control of drug policy and given it a distinctively punitive hew. The second goal is the more difficult one, namely to suggest that the hawks may have gone too far. The punishment is expensive, not so much in money terms (though the sums are no longer trivial, even in an inflation-adjusted Everett Dircksen sense) as in terms of the human costs of locking up many people for relatively minor offenses and not locking up many others for more serious offenses. Intense enforcement also increases the harms caused by drug users to themselves and others. I believe that we might well be better off if we simply punished drug dealers less aggressively; I believe that matters would be still further improved if some of the money saved by reduced punishment were spent on better quality treatment of the drug dependent. But the emphasis should be on "believe"; I cannot claim to have shown the consequences of shifting to a less punitive regime. I hope, however, that the reader will be persuaded that the question of "excessive punitiveness" is worth considering.

This is clearly the essay of an owl[12] but of one that feels that his current representatives fail to present the position strongly enough. The concession that enforcement must be maintained at its current level importantly limits the domain of policy options, particularly at a time when federal drug control budgets have stopped growing in real terms and when the corresponding state and local budgets are likely to shrink. I shall suggest that more aggressive owlishness, derived from the European "harm reduction" movement, is appropriate.

The differences among the three positions (summarized very crudely in *Table 1,* borrowed again from Nye, Allison, and Carne-

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sale) in part come from different views of what constitutes the drug problem and the sources of that problem. For hawks, the heart of the matter is the threat to youth and to American values; drug use means an abandoning of concern with others, and focusing on short-term pleasures for oneself. It is a lack of clarity about values in society and a failure to ensure that drug use is punished that leads to so many young people becoming regular users of psychoactives. The violence and health damage are merely the visible emblems of a more fundamental problem. The first *National Drug Control Strategy* says it eloquently: For "most drug users" use is the result of a "human flaw" that leads them to pursue "a hollow, degrading and deceptive pleasure." What is required is "a firm moral stand that using drugs is wrong and should be resisted." If values are the heart of the matter, then all institutions of society must join in the fight; the 1992 *Strategy* says "[T]he family, neighborhood, community, church, school and workplace must be very active in this effort. If they are not, they implicitly signal to young people that drug use is not to be taken seriously, at least not seriously enough to do anything about it."

Doves believe that individuals use psychoactive substances because they provide pleasure and that society should minimize the harm that results from the use of such substances without criminalizing the choice of a particular substance. Psychoactive drugs can harm individuals and society has a responsibility to inform adolescents about the consequences of choosing drugs and to help those who become dependent deal with the problem. But the criminal law makes those tasks more difficult as well as imposing direct costs on society.

Owls focus on the damage arising from heavy drug use by a relatively small number of those who become dependent. The health consequences are given considerable weight. Again, drug use is regarded as evil in and of itself but, in my preferred version, attention is given to the evils created by enforcement. Criminal law may be an important tool for minimizing the damage done by dangerous and attractive psychoactives in a world of imperfect decisionmakers but enforcement is a not a good in itself; indeed, one wants the lowest level of enforcement compatible with keeping initiation down and encouraging the dependent to seek treatment.[13] Drug control is also not the only goal, and higher drug use may be accepted in return for

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TABLE 1. Drug War Strategies: Hawks, Owls, and Doves

| Position | Nature of Drug Problem | Explanation for Drug Use | Policy Emphasis | Consequence of Failure |
|---|---|---|---|---|
| HAWKS | Amorality of Drug Users & Sellers | Selfishness, Lack of Clear Social Values | Tough Enforcement | Violence, Repression |
| OWLS | Addiction, Disease | Adverse Social Conditions | Prevention, Treatment, Prohibition | Continuation of Present Problems |
| DOVES | The Bad Effects of Prohibition | Pleasures from Drugs | Legalize, Inform | Large Increase in Drug Abuse |

better performance with respect to some other social goal, such as reduced spread of HIV infection.

There is much truth in the descriptive statements of all three groups. Indeed, I suspect that they are all true. However, none of them provide much help in working out what our drug policy should be. No one can describe, even very roughly, the consequences of doubling the number of treatment slots available for addicts without insurance coverage for such treatment, or what would happen if we were to increase the number of drug arrests by 25 percent. Over five years, would these result in declines of 20 percent in the extent of heroin addiction or in drug related homicides? What else might occur as a consequence, positive or negative, of these actions? The doves may be correct that many of the current evils are the consequence of prohibition but they have little basis for suggesting the consequence of the removal of those prohibitions on either the extent of use or the way that users would behave in a legalized regime.[14]

The research minded reader at this stage may object that recent experiences ought to allow us to examine the effects of at least some policy variation. Cities differ in the extent of treatment availability and stringency of enforcement. Surely that should provide the basis for determining whether tougher enforcement reduces drug use. Unfortunately, the data available at the local level are so sparse and inconsistent that research on the consequences of local variation is still in its infancy.[15]

An alternative source of insight might be the experiences of other countries, at least other developed nations. Again the research effort

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in this area is barely nascent but I will briefly show that some Western European nations have adopted much less punitive approaches and have fared no worse than the United States in terms of controlling drug use and its related harms.

But whatever the shakiness of the arguments and evidence of the various positions, the simple truth is that the hawks have prevailed; indeed their ascendance still seems to be increasing. Thus the next section deals mainly with their position, describing the many dimensions of their success. The section entitled "Changing Patterns of Drug Use and Related Problems," summarizes what has happened to the drug problem since 1980, pointing to the mixed record of success of American drug policy. A later section presents what we can reasonably claim to know about "the consequences of toughness," both good and bad. It also includes a brief survey of the experiences of Western Europe, to show what other approaches are possible. The concluding section begins with a short excursion into the political dynamics of the drug issue, explaining why the hawks almost always win, and then speculates about the likely future of US drug policy.

## THE TRIUMPH OF THE HAWKS

Many have noted that American drug policy has traditionally been heavily dependent on criminal law when compared to most other Western societies. Particularly in the last decade, the hawks have been in soaring ascendance. Though they grumble about the lack of severity in punishment of drug users and dealers, they have managed to massively increase funding for such punishment, to expand the scope of efforts to detect drug users in many settings and to intensify the severity of penalties imposed on those convicted of selling or using drugs.

### *Budgets, Legislation, and Programs*

Budget allocations help make the point. The federal budget for drug control has increased substantially over the last decade; in constant dollars it has risen from $1.5 billion in fiscal year 1980 to $6.7 billion in fiscal year 1990. Throughout that period it has been dominated by enforcement programs; the share going to such programs never fell below 70 percent and rose as high as 80 percent. The federal drug

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control budget in 1990 allocated only 29 percent of total expenditures to treatment and prevention.

Even this understates the extent of the hawks' budgetary dominance. State and local governments spend more in total than the federal government (even eliminating federal pass-throughs) but allocate a still smaller share to treatment and prevention programs. It is difficult to assemble a national drug control budget, since most state and local drug enforcement is carried out by nonspecialized law enforcement agencies and the allocation of their budgets to drug control has a very judgemental element. My own estimate is that in 1990, state and local governments spent roughly $18 billion on drug control and 80 percent of that went for enforcement.[16] This suggests a 1990 national drug control budget of $28 billion for all levels of government, with 75 percent going to enforcement.[17] Less than $5 billion went to treatment, compared to over $20 billion spent on enforcement of various kinds, mostly at the local level. Indeed, the treatment figure may have been only $3 billion, though there may be another $2 billion of private funding through health insurance.

Budget allocation is of course only one measure of the hawks' triumph. Legislatures throughout the country, with the US Congress very much in the vanguard, have dramatically increased the sentences for drug offenses, though prison overcrowding has undercut the effectiveness of these sentencing statutes. For example, in the 1988 Anti-Drug Abuse Control Act, Congress raised the mandatory sentence for selling 50 grams of crack to five years. The state of Michigan has imposed mandatory life imprisonment without parole for those convicted of selling 650 grams of cocaine. Congress has required that states impose various penalties, such as loss of drivers' licenses, for persons convicted of drug offenses, including simple possession of marijuana; federal highway funds are to be withheld from states that do not impose such penalties.

Drug testing programs have become almost ubiquitous in many institutional settings, with an emphasis on penalty rather than treatment for those who test positive. For example, many of the new Intensively Supervised Probation programs require frequent drug testing though providing few of their clients with access to drug treatment.[18] The federal government has imposed drug testing on much of its civilian work force, while perhaps half of large corporations test job applicants for drug use.

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I include the recent decisions by the Drug Enforcement Administration (DEA) and by the Public Health Service (PHS) to disallow use of marijuana for medical purposes, even on an experimental basis, as reflecting the hawkishness of current policies. DEA is responsible for the scheduling of drugs; marijuana is currently classified as Schedule I (high abuse potential, no currently accepted medical use in treatment). A number of organizations initiated a suit in 1972 seeking to have the drug reclassified as Schedule II, allowing it to be prescribed. They claimed that marijuana can alleviate nausea associated with chemotherapy as well as relieve glaucoma; it now also appears that marijuana can improve the appetite of AIDS patients. The PHS has, for the last year, allowed "compassionate" approval of marijuana prescriptions, produced on the government's marijuana farm in Mississippi, for thirteen patients.

In March 1992, the head of DEA once again refused to reschedule marijuana and the PHS announced the end of the compassionate exemption program. Both agencies deny that they had any concern with the symbolic effect of allowing marijuana to be used for therapeutic purposes.[19] On the basis of conversations with various government officials and other observers, I disbelieve that claim, though I can offer no documentary backing for this. The official argument asserts that there is no credible evidence that marijuana, as opposed to synthetic drugs containing some of its active ingredients, has greater therapeutic value. In large part this reflects the lack of research on the topic. The PHS rejection flew in the face of a survey of oncologists that found a majority who believed that marijuana should be available on prescription.[20] Indeed, that survey found that almost half of the oncologists responding currently advised their patients to use marijuana, even though the drug was not legally available. The DEA Administrator's decision reversed a remarkably strongly worded decision by the administrative law judge that the Schedule I classification was "unreasonable, arbitrary and capricious." The head of the Public Health Service did suggest that it would send a "wrong signal" to hand out a drug that can cloud judgement with respect to automobile driving or sexual behavior.[21]

The rejection of experimentation with marijuana for therapeutic purposes has an earlier parallel in the rejection of heroin for treatment of pain. In many other nations, heroin is routinely provided for relief of pain in terminal cancer patients; here it remains on

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Schedule I, not allowed for any medicinal use in treatment. There is a genuine controversy about whether other synthetic opiates might not be more effective in each of the possible circumstances that heroin is a candidate pain reliever. However, the evidence for the effectiveness of heroin is strong enough that it might be left to the individual physician to decide; leakage to the illicit market is likely to provide only a negligible supplement to existing supplies.

Marijuana's "signal" value has also been emphasized by the concerted effort to reverse the decriminalization statutes that were passed in thirteen states in the 1970s. William Bennett appeared before a number of state legislatures to argue for recriminalization and was successful in Alaska in 1990.

*Increasing Punitiveness*

One symbol of the hawks' success is that they have managed to sustain the belief that drug sellers and users are at low risk from law enforcement, a belief that has helped promote more stringent sentencing statutes. They have emphasized stories about arrested drug sellers returning to the streets more rapidly than the police who arrested them and not getting jailed until they have been convicted numerous times. The truth is more complicated. By contemporary American standards, drug selling has become quite risky and drug use may be very risky for certain classes of users.

All this depends on a great deal of speculative arithmetic, which is only summarized here.[22] Enforcement intensity is a function not simply of the total number of arrests or imprisonments for drug offenses but of the ratio of such figures to the number of drug offenses. It is hard to find good measures of the number of such offenses but if the rise in illicit drug episodes, in Drug Abuse Warning Network (DAWN), is taken as a surrogate, then it rose faster than arrests or imprisonments from 1980 to 1985 but not as rapidly from 1985 to 1990. Moreover, most drug arrests probably did not lead to serious penal sanction in the first period but in the second half of the 1980s aggressive arrest policies at last led to large increases in the number of incarcerations. Thus it is likely that the intensity of enforcement decreased, at least for cocaine offenses, in the first half of the 1980s but then rose in the second half of that decade.

So far I have not made much of differences among drugs. Law and policy appropriately make such distinctions, though not necessarily

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TABLE 2. Disposition of California felony drug arrests, 1980, 1985, 1990

| | 1980 | 1985 | 1990 |
|---|---|---|---|
| Felony Arrests | 40,451 | 63,766 | 84,538 |
| Disposed of Number Convicted | 18,800 | 30,100 | 53,200 |
| (percent of arrests) | (45) | (48) | (63) |
| Number to State Prisons | 921 | 3,366 | 10,494 |
| (percent of convicted) | (5) | (11) | (20) |
| Number to Jail | 9,700 | 22,500 | 33,900 |
| (percent of convicted) | (52) | (75) | (64) |

Source: Unpublished tabulations, California Bureau of Criminal Statistics

in appropriate ways. Enforcement has been quite drug specific and the impacts differ by drugs. Most attention in this section will be given to cocaine but it is worth noting marijuana enforcement patterns as well. In contrast to cocaine, marijuana enforcement became more stringent throughout the decade as usage dropped.

Enforcement has increased massively in absolute terms. The number of state and local arrests for drug offenses increased rapidly, from 581,000 in 1980 to 1,090,000 in 1990. The composition of these arrests changed in an important way over the same period. Whereas the 1980 total was dominated by arrests for marijuana (70 percent) and possession (82 percent) offenses, in 1990 heroin/cocaine[23] arrests had come to exceed the number for marijuana (591,000 versus 391,000) and distribution arrests now accounted for a much larger share than in 1980 (27 percent versus 18 percent). In effect, the average seriousness of arrest offense has increased sharply.

Arrest is only the first step in the criminal justice process; it is conviction and sentence that provide the principal punishment, though arrest itself can lead to seizure of drugs and other assets. At the national level we cannot systematically trace through the disposition of arrests prior to 1986. We have to rely on fragments of data collected for a few states on an occasional basis to get a sense of how many drug offenders were imprisoned during the earlier years.

The best data cover felony drug arrests in California; *Table 2* shows the disposition of these arrests in 1980, 1985, and 1990.

The number of felony drug arrests disposed of increased by about 21,000 in each half of the decade. What changed dramatically was

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the disposition of those arrests. The percentage convicted rose, particularly after 1985, and the percentage of convictions resulting in prison sentence went up dramatically. The total number of persons sent to prison for drug offenses rose threefold between 1980 and 1985 and tripled again in the following five years; over the entire decade the figure rose from less than 1,000 to over 10,000. A focus simply on the number of drug arrests fails to capture the increasing stringency of enforcement.

Nationally the only available data on the sentencing for felony drug convictions cover 1986 and 1988.[24] In that two year period there was a very sharp increase (from 135,000 to 225,000, approximately a 70 percent rise) in the number of persons convicted of felony drug trafficking or possession charges.[25] The number receiving state prison sentences (i.e., more than twelve months) rose from 49,900 to 92,500, though there was a modest decline in their expected time served from twenty-two months to twenty months.[26] In 1988 drug offenses accounted for approximately one-third of all felony convictions in state courts.[27]

The most recent year for which available data permit rough estimates of prison and jail years meted out for drug felonies by state courts is 1988. About 90,000 persons were sentenced to prison, and another 65,000 were sentenced to local jails. The federal court system also imposes punishment on drug dealers. Though federal drug convictions constitute a small share of the total, the average time served for those incarcerated is much higher than for state sentenced offenders, reflecting mandatory penalties for many drug selling offenses of ten years or more and no parole. In 1988 federal courts generated an estimated 50,000 years of expected prison time for drug dealers, compared to only one-tenth that amount in 1980. That reflected increasing numbers of convictions, rising sentence length and, most significantly, a rise in the share of sentences that the inmate expected to serve; this last was the result of the imposition of sentencing guidelines and the abolition of federal parole. The total of federal and state incarceration figures for 1988 was about 200,000 cell years; this is perhaps ten times the 1980 figure.

### *The Penal Risks of the Drug Trade*

One way to assess what this punishment represents is to consider the risks of arrest faced by users, and the risk of imprisonment faced by sellers, of cocaine and marijuana.

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To calculate roughly the 1990 absolute risks per user year for the two drugs, we need estimates of the total number of current users. If there were 15 million marijuana users, a relatively generous figure based on the survey data,[28] then they faced an average risk of 2 percent of arrest in that year; though this seems low, note that in steady state that amounted to a one in five chance of being arrested in a ten year using career. For cocaine, with a much smaller user base (no more than perhaps 5 million, ignoring those who use less than once per month), the annual arrest risk was 6 percent. The risk in a ten year using career might then be as high as 60 percent.

These are, of course, very aggregate calculations. Not all users are at the same risk of apprehension. Those who use frequently might be expected to be at much higher risk because they engage in more of the risky transaction of purchase. But there are other characteristics that seem to be associated with risk of arrest for drug possession, in particular race and gender. In the District of Columbia, of those residents arrested for drug possession between 1985 and 1987, 96 percent were African-American; 82 percent were male. No reasonable estimate of the prevalence of drug use in different populations would suggest that this represented the share of African-Americans or males in the drug using population. These percentages probably reflect the fact that many possession arrests are failed sales arrests; a seller is caught with drugs but not in the act of selling and the seller population in exposed situations (i.e., selling on the street and in crack houses) seems to be predominantly male and (in the District of Columbia) African-American.

In summary, some user groups may be at very high risk of apprehension, others at quite modest risk. That is not a casual observation, since I shall suggest later that it appears that the big declines in drug use have occurred among the groups at low risk of arrest.

For sellers the arrest risks differed even more substantially for the two drugs. Using the same assumptions as Reuter and Kleiman[29] concerning the ratio of buyers to sellers for each drug, marijuana sellers may have faced not much more than a 10 percent probability of being arrested in the course of a year of selling; the comparable figure for cocaine might be as high as 40 percent.

I estimate that the total cell years in 1988 for marijuana sellers was about 40,000 and for cocaine sellers about 110,000. The ratio of

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marijuana to cocaine is surprising in light of the great concern attached to cocaine use. But the federal courts, which provide clearly separated figures for the different drugs, show a similar ratio. The cell year calculations are more speculative than those for arrests, but 110,000 cell years for a population of perhaps 350,000 cocaine dealers suggests that by 1988 that activity had indeed become a risky one. A study of drug dealers in Washington, D.C. in the late 1980s[30] estimated that street sellers of drugs faced about a 22 percent probability of imprisonment in the course of a year's selling and that, given expected time served, they spent one-third of their selling career in prison.

Does this make drug selling appropriately risky? One-third of one's time in prison strikes me as a lot. On the other hand, the risk per selling transaction is extraordinarily low; a seller who works two days per week at this trade may make 1,000 transactions in the course of a year. His imprisonment risk per transaction is only about 1 in 4,500; by that metric it is a great deal lower than the risks associated with other crimes, such as burglary and robbery. Another way of expressing the risk is that a dealer may spend a day imprisoned for each ten sales transactions.

In many ways these figures mirror the realities for property crimes. Most robberies and burglaries result in no arrest; yet those who engage frequently in robbery or burglary are likely to spend a significant portion of their criminal careers incarcerated. So it appears to be for those who are regular drug sellers, at least in exposed settings.

## CHANGING PATTERNS OF DRUG USE AND RELATED PROBLEMS

By historic and international standards, use of illegal psychoactive drugs in the United States in the early 1990s is extraordinarily high.[31] Moreover, that drug use is associated with more severe and diverse problems than those associated with illegal drugs in other periods or societies. It is almost certain nevertheless that the prevalence of drug use has declined sharply from the dizzying heights of the early to mid-1980s and is likely to continue to decline. These two discordant facts present a dilemma in assessing the effectiveness of current policies. Should we focus on the high absolute levels, and conclude

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that these policies have failed, or on the declines and conclude that they are finally succeeding?

In any assessment it is important to note that the levels of drug use and drug problems (as well as their declines) are far from uniform across population groups. Drug abuse or dependence[32] is increasingly concentrated in inner-city populations and appears to be disproportionately a problem for the minority community, particularly inner-city, young, African-American males. Drug use apart, inner-city communities have been much more affected by the violence and disorder surrounding drug distribution. This skewing of adversities has had an important influence on the politics of drug policies. For most of the nation the drug problem is lessening but for many poorer communities there are few, if any, signs of relief; this exacerbates the growing sense of a division within society, the emergence of a hardening into "Two Nations."

*The Prevalence of Drug Use*

The broad population surveys, of the household population and of high school seniors, tell a consistent story.[33] Initiation into drug use (as measured, for example, by the percentage of successive cohorts of 18 year olds reporting use in past year) escalated rapidly in the late 1970s and early 1980s and then began to decline by 1986 or slightly earlier. The peaks were alarming; in 1978, 11 percent of high school seniors reported using marijuana on a daily basis in the previous month. Every number is now down sharply from its peak; for example, by 1991 less than 2 percent of seniors reported daily use in the previous month.

The declines, as reported in the surveys, have been surprisingly evenly spread across age/race/sex groups. The surveys also have shown a complex and changing relationship between education and drug use. In 1985 prevalence rates among males born between 1959 and 1964 were very similar for high school graduates and for dropouts; indeed the former showed slightly higher rates for both recent use (past thirty days) and past use (last twelve months). By 1990 the rates had fallen much more sharply for the high school graduates, particularly for past use. Differences in the declines for recent use were less marked, perhaps because this included more people who were habituated to drug use. The emerging negative

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correlation between education and cocaine use is consistent with the changes in cigarette use.[34]

The surveys provide mixed support for hypotheses about higher rates of drug use among African-Americans and Hispanics. The high school senior surveys consistently show sharply higher prevalence rates among whites.[35] However, the National Household Survey shows higher rates for African-Americans; in the age group 26–34 for example, in 1990, the percentage reporting some use of an illegal drug in previous month was 13.7 percent, compared to 9.5 percent for white respondents.[36]

The broad surveys can reasonably claim to provide a valid measure of trends in the extent of drug use among the general population, though they have serious weaknesses even in that role. Increased stigmatization of drug use reduces the willingness of respondents to report that they are actually users; however, that stigmatization also reduces the extent of use. Thus the surveys may exaggerate the downward trend in use but it is unlikely that they misrepresent the direction.

But no one doubts that the broad population surveys miss a great deal of the most important behavior, namely frequent drug use. There are at least three reasons for this. First, the surveys do not include some critical populations in their sampling frames (for example, the homeless[37] and prisoners) who are believed to have high rates of drug abuse. Moreover, the size of these noncovered populations has risen and their composition has changed; both populations now seem to include higher percentages with drug abuse problems than they did in 1980. Second, those who use drugs frequently, even if formally included in the sampling frame, are likely to be more difficult to reach because they behave more erratically. Third, the response rate for the survey has declined from 83 percent in 1985 to 79 percent to 1990; this nonresponse increase may well be related to increased disapproval of drug use and thus lower willingness to even participate in a survey.

Moreover, the credibility of the surveys as a good representation of the nation's drug problems was undermined in the late 1980s by the dramatic discrepancy between the most publicized findings of those surveys and public perception of the changing problem. While the surveys pointed to substantial declines in drug use, it was widely believed that the drug problem was getting a great deal worse. The

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surveys also pointed to quite modest numbers of persons with severe drug problems; for example, the number of persons using cocaine weekly or more frequently was estimated at less than 1 million, which seemed inconsistent with the severity of cocaine-related problems.

Two official indicators supported the popular beliefs. DAWN reported data on the involvement of drugs in Emergency Room (ER) cases and in Medical Examiners' (ME) reports on deaths. DAWN, in contrast to the survey data, showed dramatic increases in cocaine mentions throughout the 1980s; the total number rose more than tenfold between 1980 and 1988. Beginning in 1988, the Drug Use Forecasting (DUF) system collected data on the prevalence of recent drug use by arrestees in twenty major cities, relying on analysis of urine specimens. It found very high rates of drug use in the arrested population and produced estimates of the number of frequent users that were very much higher than those derived from the household survey. Moreover, both DAWN and DUF pointed to a concentration of problems in the inner city. DAWN which increasingly measures the extent of drug dependence,[38] also suggested that whatever is happening to drug use generally, the number of cocaine dependent persons rose substantially between 1980 and 1990.[39]

*Dependence*

Measurement of the extent of drug dependence or frequent use is casual, almost to the point of irresponsibility. Though it is often asserted that there are 500,000–750,000 heroin addicts in the United States, it is impossible to find any systematic estimates post-1980; the number has its origins in murky and questionable manipulation of little understood data series.[40] It is, however, reasonably well documented that heroin use increased rapidly during the period of about 1967 to 1973 and that the number of new initiates fell rapidly after that. However, if the correct figure is 750,000, then the United States, fifteen years after the end of the epidemic of heroin initiation, appears to have as high a rate of heroin dependence as any developed nation.[41]

The DAWN data suggest that the heroin addicted population is still dominated by the cohort of inner-city minorities who first became addicted around 1970, when they were in their late teens and early twenties. The population of DAWN heroin ER cases is about 50 percent Hispanic and African-American, and getting older;

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whereas 32 percent were over thirty-five in 1983, that percentage had risen to 50 percent by 1989.[42] Data on admissions to publicly funded treatment programs also point to an aging population that is dominated by minorities. Most heroin addicts have been in drug treatment programs frequently but heroin addiction, at least in this population, shows similarity to alcoholism; it can be characterized as a chronic, lifetime, relapsing disorder. DUF shows older arrestees to be more likely to test positive for opiates (almost exclusively heroin) but also shows surprisingly high rates among youthful arrestees, suggesting perhaps a resurgence of heroin initiation among the criminally active.[43] The new initiation may occur primarily among those who are already regular cocaine users.

More attention has been given to measuring the prevalence of frequent cocaine use. Indeed, there has even been a short-lived but vigorous controversy about this, with William Bennett and Senator Biden conducting an undignified shouting match about the number on national television.[44] The household survey produces an estimate of less than one million persons using cocaine at least once a week; indeed, for 1990 the figure was only 662,000. Using data from urine tests of arrestees in major cities, analysts have produced estimates of over two million.[45]

The urinalysis data show extremely high rates of cocaine use among arrestees. In most cities, over 50 percent of those arrested test positive for cocaine; supplemental interviews also show quite high rates of self-reported dependence among those who test positive for cocaine or heroin. What makes these figures particularly alarming is that arrest is not a rare event for young males, particularly less educated youth in large cities. Tillman,[46] reporting on the 1956 birth cohort in California found that 34 percent of white males were arrested between the ages of 18 and 29; the figure for black males was 66 percent. The 1956 cohort came to maturity before the growth of the cocaine markets. For the 1967 cohort, Reuter, MacCoun, and Murphy found that in the District of Columbia, perhaps one-quarter of the males were charged with at least one criminal offense, mostly a felony, between ages 18 and 21.[47] For African-American males in the Washington, D.C. cohort, the rate was approximately one-third. A majority of those charged had at least one drug offense among those charges.

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The DUF data have only been collected since about 1988, so they cannot be used to describe trends over the decade of the 1980s. However, in the District of Columbia, urinalysis data have been collected since 1984. Over the period 1984–1988, there was a dramatic increase in the percent testing positive for cocaine, with little decline in the percent testing positive for other drugs. There has been a substantial drop since the peak figure of 68 percent for cocaine in May 1988 but in late 1991 the percentage testing positive for cocaine was still about 50 percent, and had been at that level for a year. DUF figures show most cities to have lower rates than the peaks of 1988 and 1989 but the declines are modest. In Chicago the cocaine positives were down to 53 percent in the first quarter of 1991, compared to the peak of 64 percent in the fourth quarter of 1989.

In summary, these, and other data, suggest that the number of drug users has declined since the peak of the early to mid-1980s. However, there has been a much slighter, and later, decline in the numbers experiencing, and causing, significant problems related to their own frequent use of drugs. An increasing share of the drug abusing population is found among the inner-city poor, as the more educated became more concerned about the health consequences of drug use. The poorer users are criminally active; their criminal activity is exacerbated by this drug use. That has enormous consequences for the politics of drug policy.

### *Costs*

It is all very well to have estimates of the numbers of drug users and abusers. What costs, social and economic, should we attach to these figures? How significant is this problem?

The federal government has sponsored a series of four estimates of the economic cost of drug abuse.[48] For 1985, the estimated economic cost was $44 billion, compared to $70 billion for alcohol abuse and $103 billion for mental illness. It is hard to know what to make of these numbers, even if taken at face value, but the simple truth is that they are essentially irrelevant for our purposes because they are dominated by what the government spends to control the problem and they miss major elements of the social costs associated with illicit drugs. Particularly troubling is the treatment of the cost of crime associated with drug abuse. This is estimated to be $13 billion, of which 90 percent is public expenditures on law enforcement; the loss

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of safety and amenity is treated as zero. Yet in terms of dollars that individuals would be willing to spend to have lower crime rates in their community, that cost might well be much larger than the figures cited above.[49]

Estimates of the number of drug users is probably not a good metric for scaling the drug problem. After all, as even William Bennett noted in the introduction to the first *National Drug Strategy,* most drug using careers are short, with only a few episodes involving drugs other than marijuana and are ended without requiring any treatment. Estimates that large numbers experiment with drugs or use drugs on an occasional basis does not mean that use of illicit drugs constitutes a major problem. Alternatively put, is there a credible base for the popular fears that briefly made drugs the leading social problem in 1988 and 1989?

Some drugs such as LSD and PCP can cause substantial and lasting damage to an individual who uses them just once; this, however, is an extremely rare event for cocaine, heroin or marijuana. It seems likely that the vast majority of those who use these latter drugs only a few times suffer little harm as a consequence. The external costs of their use in aggregate may be high, if for example they provide a substantial share of the total market for illicit drugs and that market generates violence and corruption, but the costs to the individuals look modest. Moreover, it seems likely that occasional users actually account for a small share of total consumption, so that it is also unlikely that they impose high external costs through their contribution to the violence and disorder surrounding markets.

It is appropriate then to focus on those who are drug abusers in order to obtain an understanding of the costs to individuals. The standard comparison of morbidity and mortality suggests that illicit drugs present only a moderately serious problem. Compared to alcohol or tobacco, the numbers of users, abusers, premature deaths, and disease associated with all illegal drugs together is small. Tobacco accounts for about 400,000 premature deaths annually, alcohol for about 100,000. It would be hard to sustain a figure of more than 20,000 premature deaths from the direct effects of illegal drugs; even if half of all homicides are drug related, the figure is still barely 30,000.[50] Nor are the figures for morbidity impressive. With a base of frequent users of no more than 3 million, the health effects are tiny compared to those associated with the 50 million regular cigarette

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smokers and the 10 million heavy drinkers. On the grounds of the health costs, it could scarcely be claimed that use of illicit psychoactives constitutes a social problem of the first order.

That is a highly aggregative argument. Whereas alcohol and cigarettes strike all socioeconomic groups, illegal drugs bear disproportionately, in terms both of morbidity and mortality, on lower socioeconomic status and minority populations. Thus it might be that for these populations, particularly in center cities, illicit drugs are indeed a major health issue. However, it appears that these populations are also disproportionately affected by alcohol and cigarette related morbidity and mortality, so that in relative terms illegal drugs may not be much more important.

Yet there are other, distinctive and important problems associated with illegal drugs. Alcohol is comparable to cocaine in its individual criminogenic consequences. Of those sentenced to jail terms in 1989, 29 percent reported being under the influence of alcohol (and not drugs) at the time of the offense, compared to 15 percent reporting being under the influence of drugs alone; another 12 percent reported being under the influence of both.[51] However, the high price of cocaine and the extensive illegal markets associated with it have engendered crime and violence that have sources other than the direct effect of the drugs themselves. For example, Goldstein found that the majority of drug related homicides in New York were the result of "systemic" violence (for example, disputes over territories or contractual disagreements) rather than of the psychoactive effect of the drug or the need to obtain money to purchase drugs.[52] In some cities it is claimed that half of all homicides are drug related, though the criteria used to make the classification are quite murky. Moreover, the earnings from drug markets are believed to have been important in increasing the lethality of guns used in urban crime. That lethality may have contributed to the rise in killings of innocent bystanders.

The spread of HIV through needle sharing and other drug related behaviors (such as the extreme promiscuity of crack users) is another hard-to-value consequence of drug use.[53] Over one-quarter of AIDS cases include intravenous drug use as a primary risk factor and that percentage is rising. Curiously, though, in most of Western Europe, a concern with AIDS has been a principal influence on drug policy; in the United States it has been treated as almost a separate policy

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arena.[54] In particular, it has not been given much attention in the debates with which this paper is concerned.

In the last few years, a great deal of attention has been given to the phenomenon of "crack babies," who are severely damaged by the cocaine use of their mothers during pregnancy. From an official high of 375,000 in the first *National Strategy,* the estimated number of babies annually affected by mother's drug use has fallen to 30,000 to 50,000. Moreover, it is no longer so clear that the damage suffered by most of these babies is very long-lasting. The problem is an emotionally very troubling one but may be rare in most populations.

Corruption is another cost associated with drug prohibition and its enforcement. Though there are spectacular and troubling instances of such corruption, such as that involving the homicide squad in the Miami Police Department in the mid-1980s and the more recent convictions of numerous deputies in the Los Angeles Sheriff's department, the revealed corruption seems fairly opportunistic and small scale, certainly when compared with that surrounding the enforcement of gambling laws in the 1940s and 1950s.[55]

It is difficult then to say much about the real social costs of drug use and abuse. Violence, AIDS, corruption, and crack babies are all important and distinctive consequences of drug use under current conditions. There is enough of each of them to make understandable the public panic of the late 1980s. They have all become familiar enough to make equally understandable the declining concern of the last two years. That latter effect has been hastened by the fact that the most visible effects are highly concentrated in inner-city communities.

Knowing the scale of the social costs generated by drugs is important for determining what society should be willing to sacrifice in order to attain the goal of reduced use and abuse. Our inability to provide meaningful measures, along with the visibility and drama of illegal drugs, facilitates the task of those who would have the nation become harshly punitive.

## THE CONSEQUENCES OF TOUGHNESS

To what extent can it be shown that reductions in drug use have been accomplished by the general toughening of society's approach to drug control? What are other negative consequences of toughness?

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Unfortunately, discussion of these issues must be highly speculative since there is little research on which to draw.

The punitive approach should reduce drug use and abuse by making drugs more expensive and/or less accessible. This will drive addicts into treatment and discourage adolescents from initiating use. Intense enforcement should also increase disapproval of drugs, which will lead current users to desist earlier. The available evidence suggests that intensified enforcement has had modest success in raising drug prices and has not reduced already limited access for the middle class. Disapproval of drug use has increased, and that may well have reduced initiation, but it is unlikely that this disapproval is a function of enforcement stringency.

It is even harder to determine the costs of heavy enforcement, in other than budgetary terms. Drug enforcement bears particularly heavily on the African-American population. Large numbers of young poorly educated males are being locked up for long periods in institutions that do little to rehabilitate them. Tough enforcement may also exacerbate various harms of drug use.

The latter brings us to the issue of harm reduction, the European term for the more pragmatic approach to drug problems that takes account of the fact that goals of drug control can conflict with other social goals. The concluding part of this section describes what that approach entails, how (and why) it has been implemented elsewhere, and its possible application in the United States.

### *Prices, Attitudes, and Prevalence*

Price is determined by the interaction of supply and demand. If the demand for cocaine was declining in the second half of the 1980s, as suggested by the surveys, the rising numbers entering treatment and increasing imprisonment rates, then, absent tougher enforcement, prices might have been expected to fall during that period. In fact we observe a complex pattern, with retail cocaine prices declining until 1988 and then rising for the next two years.

The failure of cocaine prices to collapse may be evidence of the effectiveness of stringent enforcement. Certainly the margins for different actors in the trade remain high and, if 1988 District of Columbia data are any guide, provide substantial wage levels (approximately $30 per hour for low level participants in 1988). But the price increase that has been achieved is surprisingly modest; late 1990

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prices were perhaps 25 percent above their 1988 nadir and close to their levels of 1986 in nominal dollars. This may reflect a growing correlation between selling and heavy use. Adult cocaine retailers are frequent users themselves; if a significant portion of their earnings from this activity go to support their own consumption, then enforcement risks will have less effect on prices.

Marijuana seems to represent more of a success for enforcement. Its price is sharply higher than ten years ago, even after adjusting for potency increases and inflation. Interdiction may well have played a role; Colombia, the low cost producer of marijuana, no longer services the US market, as a consequence of increasingly effective interdiction. The primary sources are Mexico and the United States itself, both of which are very high cost producers. Moreover, the price increase has occurred over a period during which all the indicators point to a substantial decline in demand, making even clearer the impact of enforcement.

There is only one measure of availability, which comes from the High School Senior Survey. Respondents are asked whether it would be "easy," "very easy," etc. to get a particular drug. In 1980, 48 percent said that it was easy or very easy for them to get cocaine; by 1990 the figure was 59 percent. It declined for the first time in 1991, perhaps reflecting the falling demand among the seniors; with markedly fewer buyers in this population, the market may work less smoothly. In any case, if availability is a measure of enforcement success, then it certainly has lagged the increasing toughness by a long time. Marijuana availability as measured in the same survey, has remained essentially unchanged since the survey began in 1975; each year 80 to 85 percent report that marijuana is readily available or available.

These data make it difficult to evaluate enforcement success. In the legal market, where cocaine is available as a local anesthetic, it sells for $4 per pure gram, compared to the $130 on the streets. It is not readily available for many segments of the population. Marijuana prices are high by historical and international standards; indeed high enough to perhaps encourage more use of other drugs, such as alcohol and cocaine. The question is whether less rigorous enforcement, with fewer dealers incarcerated, would much reduce price or increase availability.

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A striking feature of the general population surveys over the 1980s was the changing attitude toward both the dangers and perceived popularity of drug use. Whereas in 1980, only 31 percent of high school seniors believed that using cocaine once or twice was very risky, that percentage had risen to 59 percent in 1990; for marijuana the figures were 15 percent in 1980 and 37 percent in 1990. The responses stressed health dangers rather than legal dangers.

Fewer respondents also saw drug use as the norm. Whereas in 1980, 76 percent disapproved of using cocaine once or twice, the 1990 figure was 92 percent. The most sophisticated analysis of the high school senior survey data has found that it is these attitudinal changes which best explain declining drug use.[56]

As mentioned earlier, the evidence suggests that drug use has declined more sharply among those who have graduated from high school than those who have not. At the same time, it appears that enforcement risks have increased more for the less educated. It may well be that the more educated have greater sensitivity to the threat of arrest but the evidence is against enforcement as the primary engine for reduced drug use.

*Incapacitation*

Toughness works through incapacitation of sellers and users, as well as through the effect of deterrence on prices. Locking up sellers should raise the price of drugs by removing those who were the most willing to be dealers. On the other hand, locking up users should lower the price. Even if they use drugs while in prison, they are likely to use less; urinalysis programs for prisoners show very low use rates generally. Thus incapacitation can have ambiguous effects on prices, depending on the composition of the imprisoned population.

We have already seen that an increasing number of drug sellers were locked up during the second half of the 1980s. There was an even larger rise in the number of drug users incarcerated.

Over the second half of the 1980s there was a dramatic increase in the number of prison and jail inmates, continuing a trend that goes back to the mid-1970s. Between the end of 1985 and the end of 1990, that figure increased from 750,000 (including federal, state, and local correctional facilities) to 1,200,000. The incarcerated population became richer in drug users over that time; in 1988 nearly one-third of those sent to state prison were convicted of drug

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TABLE 3. Race characteristics of arrestees

| | Percent Black | | |
|---|---|---|---|
| | 1980 | 1985 | 1990 |
| All Offenses | 24.5 | 26.6 | 28.9 |
| Crime Index | 32.8 | 33.7 | 34.4 |
| Drug Abuse | 23.6 | 30.0 | 40.7 |

Source: *Uniform Crime Reports.*

offenses, compared to only 23 percent in 1986. Moreover, the data from local urinalysis programs suggests that the percentage of those imprisoned on nondrug charges who were drug users also rose. Taking account of both the increasing population of prisoners and the rising share that were drug users, perhaps a total of 450,000 additional drug users were removed from the population that might be involved in regular use or selling of drugs.[57]

What are the effects of this increase? In the context of an estimated 2 to 3 million frequent drug users, that is a substantial change and may do much to explain the decline in various indicators, including both DAWN and DUF. That is, declines in the numbers of persons showing up in emergency rooms for drug related problems or in the percentage of arrestees testing positive for drugs may reflect not just declines in drug using behavior but also the incapacitation of large numbers of drug users. The gains then are contingent on continued incarceration, given the lack of effective treatment in most prison facilities.

### *Other Consequences*

A standard charge against the war on drugs is that it is racist and has led to a serious erosion of civil liberties. It is certainly true that African-Americans make up an extraordinarily high proportion of those charged with drug offenses, even when compared to their proportion in criminal offenses generally or to their share of the population of frequent drug users. That does not imply racism on the part of police or courts but it does point to the possibility of selective enforcement.

*Table 3* provides data on the high and growing fraction of drug arrestees who are categorized as Black in the Uniform Crime Reports.

That share has increased dramatically over the ten years from 1980 to 1990, from less than one-fourth to more than two-fifths. The

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percentage has risen much faster for drug offenses than for others, including the more serious (represented by "Crime Index" offenses).

The emphasis on crack seems to have exacerbated this tendency. For example, the Minnesota legislature in 1989 raised the maximum penalty for possession of 3 grams of crack to twenty years; the same quantity of cocaine powder involved a maximum of five years. As it turned out, 96.6 percent of those charged with crack possession were African-American; for powder cocaine the figure was about 20 percent. The Minnesota Supreme Court overturned the statute for that reason in 1991.[58]

The high and rising drug arrest rates for African-Americans represents another dilemma for drug policy. It is in poorer sections of large cities, with high percentages of young African-American males, that the problems of disorder and violence surrounding drug distribution are most acute. These are the communities that have the greatest need for active drug enforcement. Yet that enforcement, responsive to community concerns, results in the incarceration of alarmingly high percentages of young males from the same communities.

This brings us to another concern, namely that those who are locked up are unimportant figures in the drug trades and that their sentences are too severe for the crime, particularly when prisons are regarded as more likely to worsen an inmate's behavior than to rehabilitate him. The contention about the role of those locked up is almost irrefutable because of the highly pyramided nature of the drug trade. Cocaine enters this country in 100 kilogram lots and sells in 1 gram units; under reasonable assumptions about how many others a wholesale dealer is willing to transact with, there are about 1,000 retailers for each importer. Thus most of those who are locked up must be retailers and their support personnel. There simply aren't 100,000 significant figures in the cocaine trade; indeed, there probably aren't more than 10,000 whose removal would make the trade go somewhat slower.[59]

Those locked up receive long sentences now, particularly at the federal level. The expected time served for conviction on a drug trafficking offense in federal court is over six years. Though federal courts confront the highest level dealers, they also sentence numerous minor agents of these dealers, such as the Colombian sailors who transport cocaine from that country. The sentences received by these

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agents are not light. Indeed, a horrible irony of the existing federal sentencing guidelines is that the only mitigating circumstance for shortening of the mandatory sentences is effective cooperation with the prosecutor. Unimportant agents such as sailors have little to offer, whereas the principal figures in seller networks can, if they choose, provide valuable information.

At the state level the average sentences are not particularly long by contemporary US standards but as we saw above, about 90,000 persons received sentences of at least one year for drug offenses in 1988. At a time of overcrowded prisons, even one uncomfortable with the level of incarceration in the United States must ask whether the space could not be allocated more sensibly for more serious offenses.

One response to this is that those sentenced for drug offenses are also involved in more serious offenses; the drug selling is merely a marker for these other crimes. Little data are available on this matter. In the District of Columbia in a sample of drug dealers on probation in 1988, only 5 percent reported a violent offense in the previous six months. Indeed, drug selling in that sample looked very much like a substitute for other kinds of income generating (and sometimes violent) crimes.

The issue here is that of the seriousness of the offense. Legislatures have been impressed by claims that drugs cause great harm and have consequently demanded that the criminal justice system treat this as a serious offense. As always, it is a question of emphasis and allocation of resources but I confess that it is not clear to me that marijuana selling, or even possession with intent to distribute cocaine, should necessarily lead to lengthy incarceration, particularly at a time when punishment capacity is stretched so thin. That so many of those being locked up in state prisons and local jails for drug offenses are African-Americans makes it particularly important that we judge whether this incarceration is necessary.

Moreover, there are other harms that may be exacerbated by tough enforcement. Frequent harassment of street drug sellers increases the incentives to use violence for the maintenance of market share. More variability in the purity of heroin, resulting from occasional large seizures, may cause more overdoses. Stringent enforcement has raised marijuana potency, while head shop laws

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prevent marijuana users from using water pipes; marijuana is consumed in the most harmful possible manner.

The list of conjectured harms from intense enforcement can be extended. How significant each of them is and what they amount to in the aggregate is impossible to even guess at. I believe though that they are troubling enough that one needs to consider whether there is an alternative approach to drug control that takes them into account.

### *Harm Minimization and Aggressive Owls*[60]

Illicit drug use has become a prominent issue in much of Western Europe in recent years. For example, a survey of popular perceptions of the principal public health problems of the nations of the European Community found that in almost all of them illicit drugs was one of the top three concerns, always ahead of alcohol.[61] In four countries it was identified as the leading health problem. Deaths from drug use, almost exclusively involving heroin, have increased rapidly in Germany, Italy, and Spain. Switzerland, the south of France, Italy, and Spain have HIV epidemics dominated by intravenous drug users.

Despite these concerns, the reality and rhetoric of drug policy in most of Western Europe is very different from that in the United States. The crime consequences of drug use are given far less attention, though property crime is often believed to be substantially raised by drug addiction. The health consequences dominate discussion in most of Europe, though that has led to only a moderate hatching of doves. Syringe exchange schemes, scarcely permitted even on a pilot basis here, have become common in Britain, the Netherlands, Italy, and the German cantons of Switzerland. Spain and the Netherlands, with very different social policies toward drug use generally, have given the criminal law a minor role in dealing with drug users.

The discussion of drug policy in Europe, outside of Scandinavia, is dominated by debate about harm minimization rather than minimizing the prevalence of drug use. Cannabis use, outside of Scandinavia, is almost entirely ignored. The emergence of AIDS has been the catalytic force. As the Advisory Council on the Misuse of Drugs in Great Britain said in a 1988 report, "HIV is a greater threat to public and individual health than drug misuse."[62] Policy measures that

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might increase the extent of drug use but lower the prevalence of HIV are likely to be endorsed under this hierarchy of values.

The policy view extends though to more than just AIDS related matters. If tough enforcement lessens the likelihood of drug addicts seeking treatment, then less stringent enforcement might be preferred. Some Europeans even talk about police making harm minimization choices in their tactics, for example using selective enforcement to focus on heroin injectors rather than heroin smokers, since smoking poses lower risk of both HIV and hepatitis B.

My colleagues and I conjecture that the difference in policy tone between Europe and the United States is importantly affected by the much lower prevalence of violence associated with drug distribution and use in Europe. That in turn may reflect simply the lower level of violence in European crime generally. Without that violence it is much easier to see health measures as the most appropriate response.

How successful have harm minimization policies been? Precisely because they are more concerned with reducing harms than drug use, they cannot be judged simply by the extent of drug use that they have engendered. The Dutch make a reasonable case that their very conscious adoption of the harm minimization approach has permitted their addicts to lead healthier and less crime ridden lives than their counterparts in the United States. However, the much more generous income support schemes available to prime age males in Holland may be more significant here than any facet of targeted drug policy.

Harm minimization is not a policy but a framework for making decisions which considers that drug policy, particularly related to application of the criminal law, has effects on other aspects of the quality of life. The one instance of the application of harm minimization in American drug policy is in the developing consensus that drug abusing pregnant women should not be subject to criminal prosecution for the risks that they pose to their babies.[63] The belief that such prosecutions would reduce the probability of use of prenatal care seems to have played an important role in this consensus.

However, most US owls currently do not take the harm minimization approach. Their acceptance of the need for vigorous enforcement, which precludes consideration of the negative consequences of

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that enforcement, has made their contribution to drug policy discussions of limited value so far. We now turn to the sources of their timidity.

## THE POLITICAL DYNAMICS OF DRUG POLICY

The success of the hawks is in part a function of how the drug problem has been characterized in the United States. So long as crime is the dominant part of the public image of the problem, then law enforcement is plausibly the most appropriate response. Drugs are produced by evil syndicates (the Medellin cartel), sold by ruthless gangs who kill innocent bystanders and generate fabulous incomes for the sellers (media stories about inner-city kids earning $1,000 a day[64]) operating in settings that generate neighborhood fear and disorder (street corners and crack houses); so runs the standard version of the problem.

That growing association between crime and drug use in popular perception reflects the reality of changing patterns of drug use reported earlier. As young, poorly educated males become a larger part of the population that is heavily involved with drugs, so drugs and crime have truly become more strongly associated. In this sense we are reliving the experience of the early twentieth century United States with respect to opiates. Courtwright argues that the total number of opiate addicts declined through the first quarter of this century but that the decline was much more pronounced among the middle class, where the addiction was generally associated with medical treatment.[65] The recreational user/addict, typically less educated, and more frequently a criminally active young urban male, was less likely to drop out of opiate use as disapproval increased and more restrictions were placed on access to drugs. Thus opiate addiction came increasingly to be seen as a behavior leading to crime. That helped create a climate of opinion in which criminal prohibitions on use and strict penalties against sellers received broad support; the Harrison Act of 1914 attracted little controversy.

The media reporting of the "drug crisis" has undoubtedly helped here. An analysis of prime-time network news bulletins in 1988 found that illegal drugs were the second most frequently mentioned item. Most of those news stories dealt with the drama of crime associated with drugs; few of the stories concerned drug treatment or

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TABLE 4. Preferences for different drug control programs

| | Pereent Favoring Program | | |
|---|---|---|---|
| PROGRAM | White | Nonwhite | Total |
| Interdiction | 19 | 42 | 34 |
| Prosecution/Arrest | 17 | 9 | 12 |
| Education/Prevention | 41 | 29 | 33 |
| Treatment | 23 | 21 | 22 |

Note: Responses to question: "Which program should receive the most money and effort in the fight against drugs?"

Source: *The District of Columbia 1990 Public Opinion Survey of Drug Abuse and Crime*

prevention. The standard media mention of the issue is drugs and crime, rather than addiction to psychoactive substances of varying legal status.

All this has made it difficult for owls or doves to win the debate. No member of Congress has had political problems as the result of pressing for tougher penalties or expanded enforcement. The risks in arguing for more lenient punishment of drug users or dealers are clearly very serious, in face of popular opinion inflamed to believe in the need for toughness. It is depressing to note that a 1986 "Sense of Congress" resolution demanding the additions to the federal drug control budget be split evenly between enforcement and demand-side programs has led only to a modest shift in the balance of funding, even as federal drug budgets have rapidly escalated.

There is not a lot of good survey research on public opinion with respect to drugs, in particular about what people perceive to constitute the drug problem. The most relevant research survey was carried out in the District of Columbia in 1990 and showed a lack of faith in local enforcement. Respondents were asked to rate four kinds of programs in terms of their importance for controlling drug abuse. *Table 4* presents the results for both whites and nonwhites.

Three features of these responses are striking. The first is the relatively greater faith in interdiction (stopping drugs from coming into the country) as compared to enforcement at the local level. That reverses what I take to be the growing consensus among those who analyze drug enforcement. The second is the modest support for treatment, though a majority of respondents in the survey did believe that drug treatment was the appropriate sentence for arrested drug users. Third, whites and nonwhites have notably different attitudes.

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Nonwhites are more for enforcement than whites; 51 percent of nonwhites chose one of the two enforcement options, compared to 36 percent of whites. But the nonwhites more strongly prefer that enforcement take the form of interdiction rather than arrest and prosecution in their own community. A higher percentage of whites show faith in education and prevention. But demand-side programs do get strong support from both whites and nonwhites; overall a bare majority favor such programs. Thus there may be more of a base of public opinion to support less punitive approaches than is currently believed.

## CONCLUSION

A particularly disturbing aspect of the current situation is the difficulty of dismantling the punitive apparatus that has been assembled since the mid-1980s. With declines in drug involvement among American youth likely to continue for some years, the justification for the draconian sentences at the federal level, with their personal and fiscal costs, will be even harder to sustain. The problem is increasingly that of the adult drug addicts who became dependent during the heroin epidemic of 1967–1973 or the cocaine epidemic of the 1980s.

Yet the political forces are not favorable to changing this bent in the near future. The doves are likely to be pushed back to the fringe status they held until 1987. Their appearance on center stage was fueled by the pervasive sense of despair in the late 1980s that the nation's drug problem was continuing to worsen despite tough and intrusive control. That sense of despair has lessened, reflecting at last the great decline in initiation into drug use among the vast middle class of the nation. Notwithstanding the rhetoric of liberals and conservatives alike that it is "everybody's problem," drugs now seem to be moving to another entry on the long list of ills that emanate from the inner city and poor minority populations in particular. Hawkishness may not have been the primary cause for the diminution of the problem but nonetheless the diminution occurred during the hawks' ascendancy, so that hawks find it easy to claim that "toughness worked." Those who argue that the problem also worsened during the earlier ascendancy of the hawks will find a small audience. Calls for major changes in policy, in particular for the legal

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availability of what have come to be seen as "devil drugs," no matter how stringent the associated regulation, will also have limited appeal.

Owls may do better than doves. The imagery of war ought to work in their favor; victory is often followed by a period of humanitarian outreach by the winning side, an effort to help the casualties of war. The continuing decline in initiation among America's youth will make ever clearer that the drug problem is mostly the dangerous behavior of a relatively small number of adults, caught in the cocaine epidemic of the 1980s. Maybe locking them up will start to look more expensive and less attractive than developing better quality health and social services aimed at reducing their drug use and at improving their social functioning. Owls, even if their message lacks the simplicity and clarity of the competing birds, may yet come to dominate the aviary.

ACKNOWLEDGMENTS

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ENDNOTES

[1]Punishing drug users should reduce demand; to that extent the "supply-sider" label has an element of exaggeration.

[2]This debate was given its most explicit formulation in the congressional debate on the 1988 Omnibus Anti-Drug Control Act.

[3]Joseph Nye, Graham Allison, and Albert Carnesale, "Analytic Conclusions: Hawks, Doves and Owls," in Allison, Nye, and Carnesale, eds., *Hawks, Doves and Owls: An Agenda for Avoiding Nuclear War* (New York: W.W. Norton, 1985), 206–22.

[4]Nye et al.'s tripartite division added owls to the conventional hawks and doves. Whereas hawks believed that war could be avoided only if both sides have enough weapons to impose unacceptable damage on the other and doves believed that disarmament was essential to prevention of nuclear war, owls believed in confidence building measures and other elements of process, rather than the scale and comparability of nuclear arsenals as the key to peace.

[5]The most appropriate measurement of treatment success is a vexed issue. Does one include the large number of persons who drop out early in a particular program,

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perhaps because they decide that other programs are more suitable? What constitutes success: abstinence or improved social functioning? The authoritative review is Dean Gerstein and Hendrick Harwood, eds., *Treating Drug Problems* (Washington, D.C.: National Academy Press, 1990).

[6]The argument is made most explicitly in reports of the Office of National Drug Control Policy. See *National Drug Strategy* (1989 and 1990) and *White Paper on Drug Treatment,* 1990.

[7]I shall not deal with the fringe dove movement that emphasizes the positive effects of psychoactive drugs. Thomas Szaz is probably the leading intellectual evangelist of this group; see Thomas Szaz, *Ceremonial Chemistry: The Ritual Persecution of Drugs, Addicts and Pushers* (Garden City, N.Y.: Anchor Books, 1974).

[8]Ethan Nadelmann, "America's Drug Problem," *Bulletin of the American Academy of Arts and Sciences* XLV (3) (December 1991): 24–40.

[9]Most acknowledge an exception for children; criminal prohibitions for the sale to children is a staple of dove advocacy.

[10]Recent statements of this pessimism include Peter Andreas, Eva Bertram, Morris Blachman, and Kenneth Sharpe, "Dead-End Drug Wars," *Foreign Policy* (85) (Winter 1991–1992); and *The Andean Initiative: Squeezing a Balloon,* Report prepared by the staff of the House Judiciary Committee's Subcommittee on Crime and Criminal Justice, 24 February 1992.

[11]Gerstein and Harwood, *Treating Drug Problems.*

[12]Some colleagues have argued that the imagery is loaded; after all, owls are generally thought of as wise. My own image of owls is more mixed, being derived from childhood readings of Winnie-the-Pooh, in which Owl is indeed learned (he can misspell long words) but unrealistic and self-deluded. The owls of Nye, Allison, and Carnesale exhibit some of the latter qualities.

[13]The most refined discussion of these matters is Mark Kleiman, *Against Excess: Drug Policy for Results* (New York: Basic Books, 1992).

[14]A point made by James Q. Wilson, "Drugs and Crime," in Michael Tonry and James Q. Wilson, eds., *Drugs and Crime* (Chicago: University of Chicago Press, 1990).

[15]For example, there are few cities or metropolitan areas with data on the prevalence of drug use in the general population, so that it is impossible to model the effect of policy variables on the extent of drug use. Other proxies, such as the number of deaths related to drug use, turn out to be unsatisfactory for this purpose.

[16]To estimate the share of criminal justice expenditures accounted for by drug enforcement, I separated police, courts, and corrections. The share of police expenditures on the drug "account" was measured by the ratio of drug selling arrests to Part I arrests plus drug selling arrests. For courts it was the ratio of drug felony convictions to all felony convictions. Finally, for prisons I used the share of all commitments to prison that were for drug offenses. These are all crude estimates. The only systematic effort to measure state and local expenditures on drug enforcement by police, Gerald Godshaw, Ross Pancoast, and Russell Koppel, *Anti-Drug Law Enforcement Efforts and Their Impact* (Bala Cynwyd,

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Pa.: Wharton Econometric Forecasting Associates, 1987), showed an even higher share of the police expenditures going to that effort in 1985 and 1986.

[17]It is striking just how state and local governments have succeeded in keeping the public debate focused on the federal budget allocation. State and local expenditures on treatment and prevention have been growing very slowly compared to those of the federal government, even though these services are delivered almost exclusively by the lower levels of government.

[18]See Joan Petersilia, Joyce Peterson, and Susan Turner, *Intensive Probation and Parole: Research Findings and Policy Implications* (Santa Monica, Calif.: RAND Corporation, 1992).

[19]*New York Times*, 22 March 1992.

[20]Richard Doblin and Mark Kleiman, "Marijuana as an Antiemetic Medicine: A Survey of Oncologists' Experiences and Attitudes," *Journal of Clinical Oncology* 9 (July 1991).

[21]"Out of Joint," *New Republic*, 15 & 22 July 1991.

[22]A more detailed account is given in Reuter, "On the Consequences of Toughness," in Krauss, Melvyn, and Edward Lazear, eds., *Drug Policy in America: The Search for Alternatives* (Stanford, Calif.: Hoover Institution Press, 1991).

[23]The Uniform Crime Reports system of the FBI combines heroin and cocaine arrests into a single category. It is generally believed that the increase in this category throughout the 1980s was dominated by an increase in cocaine related arrests.

[24]Bureau of Justice Statistics, *Felony Sentences in State Courts* (Washington, D.C.: 1989, 1990).

[25]Since these possession charges were prosecuted as felonies, they are presumably possession with intent to distribute rather than simple possession offenses, which in most states are misdemeanors only.

[26]The declining average time served probably reflects two phenomena. The first is simply prison overcrowding, which has led to a reduction in the share of sentence actually served. The second is that the rapid increase in the number of drug offenders receiving prison sentences means that some are now being imprisoned for less severe offenses.

[27]All of these dispositional data, both national and Californian, bear on felonies, primarily related to distribution and/or manufacture. There are literally no published data concerning the sentences received by those arrested on simple possession charges.

[28]The household survey produces an estimate of ten million current users (i.e. reporting at least one use within the prior thirty days) in 1990. Allowing for one-third underreporting gives a total of fifteen million.

[29]Peter Reuter and Mark Kleiman, "Risks and Prices: An Economic Analysis of Drug Enforcement," in Norval Morris and Michael Tonry, eds., *Crime and Justice: A Review of Research* 7 (Chicago: University of Chicago Press, 1986).

[30]Peter Reuter Robert MacCoun, and Patrick Murphy, *Money From Crime: A Study of the Economics of Drug Dealing in Washington, D.C.*, RAND: R-3894-RF (Santa Monica, Calif.: June 1990).

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[31]Mark Kleiman sensibly notes that this kind of statement ignores the prevalence of alcohol use. It may well be that the average hours of intoxication per citizen is no higher in the United States than in nations, such as France, where alcohol is more widely abused. Without denying the relevance of that measure, there are distinctive problems arising from use of illegal substances and it is worth considering differences among societies in the extent of that use.

[32]The federal government defines the use of an illicit drug as drug "abuse." Both medicine and ordinary language make a distinction between use and abuse or dependence. Though the latter two terms have different origins and formal definitions, they will be used interchangeably here to reflect levels and patterns of drug consumption that create health and/or behavioral problems to the user. None of the existing data systems allows for accurate measurement of the prevalence of one rather than the other.

[33]During the 1980s, the National Institute on Drug Abuse funded three surveys of drug use in the household population; that survey has been conducted annually since 1990. Each year since 1975 the University of Michigan has surveyed a sample of approximately 16,000 high school seniors.

[34]"Thirty years ago smoking was not associated with social class. It is now. In 1980, a quarter of professional men smoked, a third of white collar men and almost half of blue collar men..." Thomas Schelling, "Addictive Drugs: The Cigarette Experience," *Science* 255 (24 January 1992): 430–31.

[35]Nor is this simply explained by higher drop out rates among African-Americans, which would suggest that the high school senior population was a more select group within their age cohort when compared to the white seniors. Drop-out rates in recent years have been almost equal for the two populations.

[36]That difference is particularly striking since the percentage of incarcerated males aged 26–34 is much higher for African-Americans than for the rest of the population. The incarcerated males are much more likely to be drug users than the nonincarcerated; if the two ethnic groups have the same prevalence rate overall, the nonincarcerated African-American rate should be lower than the white race. Note that these are all unadjusted rates; the differences should not be ascribed to ethnicity but may be a function of urbanness, education, employment rates, etc.

[37]In 1991, the survey for the first time included homeless in shelters.

[38]The DAWN reports include data on the patient's motive for using the drug. In 1983, 42 percent reported that they took cocaine for its psychic effects (i.e. for pleasure) and 47 percent reported dependence. By 1989, 63 percent of those episodes involving cocaine were classified as drug dependence and for only 28 percent was "psychic effects" the motive for taking the drug.

[39]The number of DAWN cocaine mentions flattened out in 1988 and then fell by about 25 percent between the second and third quarters of 1989. The numbers then rose over the following two years, close to their prior peak. Little effort has been made to understand these changes, which may be affected by shifts in emergency room policies during an urban health care financing crisis, or by alterations in the behavior of addicts rather than by their numbers.

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[40]For a severe criticism of those estimates, see Reuter, "The (Continued) Vitality of Mythical Numbers," *The Public Interest* (Spring 1984). A recent review of the literature leaves me with little reason to change that critique.

[41]Italy may have a higher rate; there are sharply conflicting estimates of the total number of addicts. If one trusts numbers of unknown provenance from distant lands, it is possible that Pakistan and Thailand have higher rates of heroin addiction. See the State Department's annual *International Control Strategy Report.*

[42]The figures on age composition refer to unweighted data, which are only available through 1989. For purposes of describing long-term trends, the new weighted data are not appropriate.

[43]The evidence for a new heroin epidemic is presented in BOTEC Analysis Corporation, *Heroin Situation Assessment*, a Working Paper prepared for the Office of National Drug Control Policy, 10 January 1992.

[44]See the MacNeil/Lehrer NewsHour, September 1990; debate between ONDCP Director, William Bennett, and Senator Joseph Biden.

[45]Eric Wish, "U.S. Drug Policy in the 1990s: Insights from New Data on Arrestees," *International Journal of Addictions* 25 (3A) (1990–1991): 377–409. See also Senate Judiciary Committee, *Hard-Core Cocaine Addicts: Measuring and Fighting the Epidemic* (Washington, D.C.: 1990).

[46]Robert Tillman, "The Size of the 'Criminal Population': The Prevalence and Incidence of Arrests," *Criminology* 25 (3) (Fall 1987).

[47]Reuter, MacCoun, and Murphy, *Money from Crime.*

[48]The most recent is Dorothy Rice, Sander Kelman, Leonard Miller, and Sarah Dunmeyer, *Economic Costs of Alcohol Abuse, Drug Abuse and Mental Illness, 1985* (Rockville, Md.: Alcohol, Mental Health and Drug Abuse Administration, 1990).

[49]To get a sense of this, the reader should consider what would happen to the value of her house if the crime rate in the surrounding area reached a figure comparable to that on Capitol Hill in Washington, D.C.

[50]A better measure is Years of Life Lost (YLL) which takes account of how premature a death is; for example, the average YLL is higher for alcohol than cigarettes, since lung cancer typically strikes its victims in late middle age, while many alcoholics die in early middle age. DAWN data suggest a much higher average YLL (i.e. earlier age of death) for illicit drugs but even that would not raise the significance of illegal drugs to that of either alcohol or tobacco.

[51]Bureau of Justice Statistics, *Profile of Jail Inmates, 1989* (April 1991).

[52]Paul Goldstein, H.H. Brownstein, P.J. Ryan, and P.A. Belluci, "Crack and Homicide in New York, 1988," *Contemporary Drug Problems* (1990).

[53]Medical costs for treatment and lost wages capture only the direct costs; the increased fear associated with sexual intercourse is an instance of those indirect consequences that seem both difficult to value and potentially very important.

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[54]See the recent complaints by the National Commission on AIDS about lack of drug treatment capacity, *The Twin Epidemics of Substance Use and HIV* (1991), 7–10.

[55]This is discussed in more detail in Reuter, "Police Regulation of Illegal Gambling: Frustrations of Symbolic Enforcement," *Annals of the American Academy of Political Science* (July 1984).

[56]Jerald G. Bachman, Lloyd D. Johnston, and Patrick M. O'Malley, "Explaining the Recent Decline in Cocaine Use Among Young Adults: Further Evidence that Perceived Risks and Disapproval Lead to Reduced Drug Use," *Journal of Health and Social Behavior* 31 (June 1990).

[57]If 45 percent of the 1985 incarcerated population were drug users and the figure for 1990 were 65 percent, then the total number of drug users locked up rose from about 350,000 to 800,000. Both percentages seem fairly conservative.

[58]*Washington Post*, 14 December 1991, A10.

[59]This is not to say that the more senior figures are at low risk. Indeed, it seems unlikely that one could operate as long as five years in most American cities in the high levels of the drug market without facing substantial risk of long term imprisonment.

[60]This section draws on ongoing work being done in collaboration with James P. Kahan and Robert MacCoun.

[61]Public Opinion in the European Community, *Eurobarometer,* December 1989.

[62]The Advisory Council on the Misuse of Drugs, *Report: AIDS and Drug Misuse* (London: HMSO).

[63]I owe this example to Douglas Besharov.

[64]See for example the alarmist cover story in *Time*, 9 May 1988, 21–33.

[65]David Courtwright, *Dark Paradise: Opiate Addiction in America Before 1940* (Cambridge: Harvard University Press, 1982).

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*Mark A.R. Kleiman*

# Neither Prohibition Nor Legalization: Grudging Toleration in Drug Control Policy[1]

IN THE DEBATE OVER THE LEGALIZATION OF DRUGS, each side can cite horrible examples of the failure of the other's policies. Advocates of legalization can point to the role of forbidden heroin and forbidden needles in spreading AIDS and to the violence incident to the traffic in illicit cocaine.[2] Advocates of prohibition can point with equal justice to the colossal price in death and disease exacted by licit tobacco and to the massive damage done by licit alcohol to drinkers, their families, and the victims of alcohol-induced crimes and accidents.[3]

Even if we restrict our gaze to alcohol, we can see both a failed prohibition and a disastrously inadequate attempt at control by regulation and taxation.[4] Not only did Prohibition generate crime and corruption, it also deprived millions of nonproblem drinkers of a harmless (to them) source of pleasure and comfort. To judge whether that collection of harms was, in the aggregate, greater or smaller than the harms done by alcoholism, binge drinking, fetal alcohol syndrome, drunken driving, drunken assault, and drunken accidents ranging from fires to pregnancies would require a truly heroic feat of imagined measurement.

It seems, then, that the nature of (some) chemicals, the human nervous system, and American society are such that either complete prohibition or virtually free legal commerce on the model of alcohol and nicotine is likely to carry heavy costs. That being so, we can

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either debate which set of costs is likely to be smaller for any given drug or we can try to invent a third course, some control regime between prohibition and legalization that would moderate the disadvantages of either extreme.

Indeed, it would be strange if one could not devise a set of laws and programs much tighter than the light taxes and poorly-enforced age restrictions now applied to alcohol, yet much looser than the virtually total prohibition now applied to marijuana. It would be almost equally strange if one could find no drug too dangerous for the current alcohol regime yet not dangerous enough to need the current marijuana regime. Perhaps alcohol and marijuana might both belong in that middle category, treated neither as legitimate articles of commerce nor as contraband, but as grudgingly tolerated vices.

## THE CONCEPT OF VICE

What is a vice? We are not concerned here with the "vice" that is the antonym of "virtue," but the "vice" in the phrase, "vice squad": not, that is, with cruelty, hypocrisy, arrogance, cowardice, and laziness, but with drug-taking, gambling, and commercial sex. Some capsule scenarios may illustrate the characteristics of drugs that make them potentially vicious (in the etymological rather than the current meaning of that word) and thereby constitute a reason (whether or not a good enough reason) to institute special public policies, beyond those applied to most goods and services, to control them:

1) A man beats his wife in a drunken rage.

2) A chronic heavy cigarette smoker fails on her fifth attempt to quit, and her hacking cough gets worse.

3) A pregnant woman continues to take cocaine despite warnings about possible fetal damage.

4) A high-school junior with previously good grades spends most of the year under the influence of marijuana, and doesn't learn much.

5) A heroin user steals a television set to support his habit.

6) Two sixteen-year-olds share a few wine coolers and then have their first experience of coitus, unplanned and unprotected.

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7) Under the influence of alcohol, an old man falls asleep with a lit cigarette, causing a fatal house fire.

These scenarios do not, of course, prove that all drug use is vicious or that all bad behavior comes from drug abuse. Knowing that a man beats his wife while drunk does not imply that he would never beat her if he were always sober. Nor do they separate drug-taking from other activities. Item 4 would make equally good sense with "in front of the television set" substituted for "under the influence of marijuana;" item 2 could be about overeating and obesity rather than smoking and coughing. But insofar as they represent plausible stories, and stories that are more plausible about drugs than about breakfast cereals, these scenarios help indicate why drug-taking might reasonably be a topic of special legislation.

A vice, in this sense, may be defined as an activity voluntarily engaged in that risks damage and threatens self-command.[5] It is a special kind of hazardous consumer product, in which some of the hazards are behavioral: that is, where part of what some consumers are in danger from is their own faulty decision making about whether, how often, when, where, and how much to consume, and how to behave afterwards.

The damage done by a vice may be purely behavioral, or it may be physical as well. The behavioral ill effects may last only as long as the pleasure, or they may through chronic use become part of the participant's character. The behavioral risk may be limited to consumption of the vice itself (as with a person unable to stop smoking) or it may extend to other behavior (as with a drunken assailant). We may distinguish these as "addictive" and "intoxicating" vices, respectively.

In the case of the addictive vices, the vice consumer will often be the only person at direct risk, although even in that case insurance or other risk-spreading mechanisms are likely to spread the costs around. Intoxicating vices are more likely to involve other immediate victims.

## WHAT MAKES A VICE?

Potential vices are as varied as the kinks in the human psyche. Anything that is desired obsessively can generate behavior that seems

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irrational not only to outside observers but to the actor himself or herself in dispassionate moments. Gems, sports cars, paintings, rare books, postage stamps, coins, wealth, and power are all vices for some of those who collect them.

Still, it is possible to isolate characteristics of activities that will tend to make them vices of either the addictive or the intoxicating sort.

Anything will be an intoxicating vice to the extent that it reduces the capacity for rational self-direction. To be rationally self-directed, one must be able to correctly perceive what one is doing, to imagine its consequences, to evaluate those consequences, and to shape one's behavior in light of that evaluation.

The capacity to postpone gratification, and in particular to accept a moderate amount of immediate unpleasantness to avoid a large amount of deferred unpleasantness, is a hard-won and often incomplete victory of the process of growing up. It is also fragile, as anyone who has been very ill, or in battle, or drunk can testify.

As intoxicants, drugs stand out from other potential vices because of their direct and mechanical effect on the nervous system. This is less true of addictive vices. The physiological dependency most characteristic of the opiates gives some cases of drug addiction a physical substrate absent from addiction to soap operas, but most drug addiction—more broadly, most compulsive drug-taking—depends on faults in human decision making that make themselves felt in a wide range of activities.[6] Physiological dependency, or drug addiction proper, is the most spectacular but not the most important source of irrational drug-taking behavior.[7]

Any activity in which the reward and punishment pattern poorly represents the actual costs and benefits will be a frequent locus of behavioral departures from rationality. If the rewards are immediate, certain, powerful, and clearly linked to the activity, while the punishments are delayed, uncertain, diffuse, and hard to trace, then the practice will be behaviorally reinforced even though its costs exceed its benefits as valued by the participant. Thus an addictive vice is simply a potential bad habit.

Note that this account makes vices different only in degree from many commodities and activities. A vice has in abundance charac-

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teristics that many commodities have more or less: the tendency to induce error (especially excess) and a threat to self-command.

## SHOULD WE HAVE VICE POLICIES?

Assume for the moment that drug-taking has the characteristics of a vice: that it is more prone than the typical activity both to escape control by its participants' voluntary self-restraint and to damage their capacity to exercise such self-restraint in other areas, in their own interest and in consideration for others. So what? If they damage themselves, why does that concern the state? If they damage others, do we not have criminal and civil laws to restrain them, and nonlegal institutions ranging from families to markets as well? Did not John Stuart Mill demonstrate that the greatest good of the greatest number is served by leaving "self-regarding actions," including private consumption choices, in the hands of individuals?

There are at least four questions entangled here, one normative and three more or less empirical.

1) If there are topics about which individuals systematically make such bad choices for themselves that their welfare, as they measure it, can be improved by state interference in their private affairs, is such interference justified?

2) Are there such topics, and can they be identified?

3) To what extent will damage to individual capacities for self-regulation spill over and damage other persons?

4) Given the imperfections in the processes of legislation and enforcement, will actual vice laws (assuming there are any) make matters better or worse for potential vice consumers and others? In particular, will vice laws tend to excessive meddling with harmless pleasures, and vice enforcement to excessive intrusiveness?

A utilitarian such as Mill, or any other proponent of a welfarist theory of the good, is forced to concede that an intervention that makes those subjected to it better off is justified. Those who value personal autonomy over personal well-being will tend to disagree.[8] I have no hope of settling that question here, only to pry the question free from the notion that Mill has already settled it in the negative.

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The real force of the argument for absolute noninterference stems from the notion that no person will choose to damage himself. The rationally self-directed individual is assumed in so much economic, legal, and philosophical discourse that it is worth reminding ourselves that perfect self-command is no more to be met with in nature than is a perfect vacuum. Self-command is an achievement, not a given; even the wily Odysseus preferred to face temptation with the aid of physical restraint.

There is more basis for doubting that political institutions are well-designed to identify vices and to erect appropriate control regimes. Not only is the identification of vice likely to engage the most virulent social prejudice, but vice control seems to share with vice itself a tendency to excess. This line of argument is enough to support a rebuttable presumption against vice legislation, but the absolute presumption claimed by the strict libertarians seems harder to justify.

Nor is it plausible that, in a society based largely on self-direction, the costs of widespread failures of self-control will fall entirely on those individuals who suffer from them. A liberal society counts on its (adult, healthy) members both to manage their own affairs in their own interest and to restrict their behavior within the bounds of civil conduct and the rights of others, as embodied in laws and customs. No one does either of these tasks perfectly, and in any social group some will do them less well than others. But the less capable of self- management the members of any society are, the more formal social control they will require and the less happy that society will be under a liberal regime. "Whoever does not rule himself will be ruled by another."

Liberal institutions, including the market and the criminal law, rely on individuals' capacities to manage their own affairs in their own interest both to restrain their behavior in deference to the rights of others and to secure their cooperation for private and public purposes. Direct coercion (for example, imprisonment) is extremely rare, because it is extremely expensive, compared with incentives, including coercive threats.[9] Anything that makes individuals more present-oriented and less self-controlled will require an increase in external controls to achieve the same level of security for others.

Moreover, anything that makes someone a less competent steward of his own welfare is likely to make him also a less desirable coworker, neighbor, or fellow citizen by reducing his capacity and willingness to engage in the myriad forms of voluntary cooperation that characterize the workplace, the neighborhood, and the polity.

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Thus the regime of liberty is not indifferent to the character of its members, and, paradoxically, liberal societies may need more restrictive policies about vice than regimes that rely more on coercion.

This becomes less paradoxical when it is remembered that the individuals who constitute a free society occupy the supreme office of citizen and voter. Under a democratic regime, the character of the populace is the character of the ruling class, and thus self-evidently a matter of political, and not merely private, concern. As Machiavelli warned, a corrupt people will not long retain its freedom.[10]

But will not this line of reasoning lead to regulating everybody's breakfast? That will indeed be the case if policymakers and citizens lack the virtue of moderation. Surely the range of possibly damaging activities is far broader than the range that could be usefully regulated.

One key piece of evidence that some practice may be so vicious that it needs to be coercively interfered with is that many of its participants regret their initial choice to adopt it. If the vice is an addictive one, there will be further evidence in the form of repeated and imperfectly successful attempts to quit and demand for external, professional help in doing so. If the vice is an intoxicating one, the regret will be centered less on the activity itself—its frequency and quantity—than on the resulting behavior.

Simply by treating their own behavior as a problem, participants in any activity provide evidence that it fits the model of rational self-control only imperfectly. To be sure, those who develop bad habits will not be the only ones to complain. Other sufferers—families, coworkers, neighbors, the victims of crimes and accidents—will add their voices to the chorus. But it is the testimony of those who find their own behavior slipping out of their control that is the most persuasive in overcoming the presumption that some particular activity is well-regulated by unconstrained individual choice.

## ELEMENTS OF VICE POLICY

What can we do about vices, in the interest of their consumers and others? Conceptually, the list is short:

1) We can try to develop in the population at large better personal decision skills, better impulse control, and more awareness of self-command as a problem in general and the specific threats to it represented by particular potential bad habits.

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2) We can create conditions that discourage the use, and especially inappropriate or excessive use, of vicious goods and services, by making them expensive or hard to obtain, and by restricting the distribution of promotional messages and fostering the distribution of antipromotional messages.

3) We can attempt to temper the bad results of vice consumption by making the world a safer place in which to be intoxicated (or by creating spaces for safe intoxication), by helping those who have become habituated, and now wish to stop, in the process of quitting, and by coercing those whose vice consumption is a problem for others either to moderate or cease their vice consumption or to reduce the behavior that causes external damage.

*In the instance of alcohol consumption, the range of possible* policies would then include: promoting the ideal and skills of moderation and self-command; spreading information about the risks of drunken behavior and alcohol habituation; taxing alcoholic beverages; restricting when, where, how, to whom, and in what quantities they may lawfully be advertised and sold; enforcing those restrictions against buyers and sellers; improving general highway safety to reduce the frequency of fatal injury from drunken driving; suspending the driving licenses of those who drive drunk; and requiring those who drive drunk, or commit drunken assaults, to abstain from alcohol. The requirement of abstinence could be enforced either directly on identified problem users or indirectly, via (licensed) alcohol sellers.

A different conceptual map would divide vice control regimes into laws and programs. Laws include taxes and regulations. (Prohibition can be conceived as the extreme of either taxation or regulation.) Programs enforce the laws, educate and persuade, or offer help to, and impose control on, identified problem users.

## WHAT IS GRUDGING TOLERATION?

The analysis above suggests that free legal availability of all psychoactives is unlikely to be the best policy. But prohibition has equally obvious costs. Can we construct a middle course that will, for some drugs, outperform either of the extremes?

One way to think about doing so is to start with the current alcohol control regime. Of all the drugs not completely banned for

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nonmedical use, alcohol is the most tightly regulated; most of the possible forms of restriction are now present, if only in embryo. Still, a point-by-point examination of alcohol policy suggests how much room there is for further tightening, short of prohibition. For each proposed step there are one or more objections, disadvantages, design problems, and questions of enforceability. But for now it suffices to show how broad the possibilities are for discouraging drug abuse without forbidding all drug consumption.

*Taxation*

Alcohol is subject to special taxation (or the equivalent in monopoly pricing) at both the federal and the state level. The tax burden on the average drink is about ten cents, roughly one-tenth of its total price.

Yet the external costs of alcohol use (the costs imposed on nonusers via health insurance, accidents, etc.) are at least three times that high, even without reckoning the costs of crimes committed under the influence.[11] A good case can be made for alcohol taxes at the level of a dollar per drink.[12] The effect on drinking, especially heavy drinking and drinking by adolescents, would be substantial.[13]

*Promotion*

Advertising for distilled spirits is banned from television by broadcast industry practice, and federal regulation forbids advertisements that stress the potency of competing brands. Packages, but not advertisements, are required to carry health warnings. There are some attempts through "public service" messages to discourage drunken driving and underage drinking and promote moderation, but there is no mass-media campaign against drinking, or even drunkenness, as such. (The media outlets and advertising agencies that contribute talent and advertising space to the Media Partnership for a Drug-Free America derive much of their revenue from alcoholic-beverage advertising.) School-based antidrug programs cover alcohol as well as the illicit drugs, but the movement for controls on alcohol advertising aimed at the young is opposed on free-speech grounds.

These restrictions on promotion and efforts at "antipromotion" are quite modest by comparison with the potential. Advertising could

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be banned entirely (with the useful side effect of removing an important incentive for media self-censorship with respect to the alcohol problem) or its content could be restricted to facts about the various products, their prices, and where they can be obtained, after the fashion of the "tombstone" ads to which securities underwriters are limited. A serious campaign of negative advertising, like the one currently mounted against illicit drug use by the Media Partnership for a Drug-Free America, could be supported with public funds. Since alcohol is now more socially acceptable and less feared than the illicit drugs are or were, and since there is in fact considerable bad news about alcohol to disseminate, the effect of such a campaign might be quite substantial, as the antismoking campaign since 1964 has been.

*Restrictions on Sellers*

Sellers of alcoholic beverages, whether for on-premises consumption or for carry-out, are forbidden to sell to anyone visibly intoxicated. They have no responsibility not to provide the means of chronic alcohol abuse, even if they are aware of it. Tavernkeepers but not package-goods sellers may be held responsible for drunken misbehavior, including automobile accidents, by persons they have served. Tavernkeepers are also required to maintain orderly premises. Times of sale are restricted by law, and licenses to sell are kept in short supply and are subject to revocation for seller misbehavior. (In some states, package sales are a state monopoly.) Sellers are responsible for ensuring that customers are of legal age to drink.

There is little evidence that tighter time-and-place restrictions, or a reduction in the number of licenses, could noticeably reduce alcohol abuse, but such policies might bring benefits to the neighborhoods now inconvenienced by the presence of bars and liquor stores. A more drastic step would be to impose more liability on alcoholic beverage sellers for the behavior and welfare of the drinkers they serve: to require them, as stockbrokers are required, to "know their customer" and to act in a quasi-fiduciary capacity. This would mean training sales personnel to recognize the stigmata of chronic alcohol abuse, or even requiring buyers to establish relationships with a limited number of sellers who could then monitor consumption levels. It could also mean requiring tavernkeepers to provide a safe

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and comfortable space in which to enjoy the effects of the drug, and to allow or even require their customers to remain within it as long as the influence lasts.

*Restrictions on Buyers*

Drug users are heterogeneous; a substance harmless to one person can wreck the life of another and turn a third into a social menace. That is the great objection to blanket prohibition and blanket legalization alike; either one makes fewer discriminations than the topic demands.

Possible restrictions on buyers include limits on who can buy, limits on quantity (as a way of addressing the harms done to and by heavy users), and limits on behavior under the influence. Of these, only the last is usually enforced against the buyers directly; the others are enforced against the sellers, who then bear the responsibility for making the restriction felt by the buyers.

Of the possible range of possible criteria about who may buy alcohol, current US law makes use of only one: age. In effect, every American who turns twenty-one is given an unconditional and irrevocable license to drink. If even this restriction could be strictly enforced, the alcohol problem would shrink considerably; about four in ten male high-school seniors report having had five or more drinks at a single sitting within the previous two weeks.[14] Obviously, alcohol leaks through the age barrier by the gallon, primarily, it appears, through the simple expedient of having those who are of age buy for those who are not.[15]

Other possible criteria for a "drinker's license" might include knowledge of facts and safety rules about drinking, as demonstrated on a test like a written driving test or by completion of a training program like driver's education course; call this "positive licensure." The alternative is "negative licensure": every adult has a license unless it is lifted for a history of misbehavior such as drunken driving, drunken assault, or distribution of alcohol to unlicensed persons. (Why should drunken drivers lose their right to drive but keep their right to drink?) Under either system, a drinker could voluntarily cede his license, either as an aid to self-control or to secure the economic benefits, such as discounts on automobile, life, and health insurance, likely to be offered to nondrinkers.

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In either case, eligibility to drink would need to be signified by a document, which could either be a new document, patterned after a driver's license, or the driver's license itself, with additional markings. This would allow the seller to verify the buyer's eligibility, as is currently done with proof of age. Such a system of licensure would also allow the enforcement of personal quantity limits for alcohol purchase, an idea which has in the past been tried in Oregon and some parts of Scandinavia but ran aground on administrative problems.

A less drastic, but also less effective, way to deal with the tendency of some problem drinkers to commit crimes and cause accidents would be to impose the order not to drink on them directly, rather than on the industry. Enforcing such an order would require either the compulsory administration of a drug to counteract the effects of alcohol (as naloxone blocks the effects of heroin) or to make them unpleasant (as Antabuse does for alcohol) or the development and administration of chemical tests for past alcohol use, like the chemical tests now available for past use of illicit drugs.

This list of possible components of a policy of grudging toleration toward alcohol is not quite comprehensive enough to serve for all possible drugs. It reflects the fact that alcohol is a relatively mild intoxicant at low doses, widely and frequently used. For drugs with much more profound effects, which most users take very infrequently, and which are not integrated into existing social rituals—for example, the psychedelics, including LSD, mescaline, psilocybin, ketamine, and MDMA—one could imagine a control regime based on a small number of licensed places of administration, employing licensed personnel, who would have the responsibility and the authority to exercise custodianship over drug-takers during their period of intoxication and recovery and would be liable to their customers and to third parties in the case of bad outcomes. Ideal control regimes might be nearly as various as drugs themselves; surely they are not as bipolar as the current control regimes.

## GRUDGING TOLERATION IN ACTION: THREE EXAMPLES

Without specifics, grudging toleration is no more than a slogan. But specifics must involve specific drugs; I have chosen alcohol, marijuana, and cocaine as illustrations. (What forms grudging toleration

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might appropriately take for other vices is a topic for another day.) The actual details of any control regime would require volumes to describe; no more than a sketch is possible here. Even if fully-detailed plans could be presented, they would be of limited value. Actual essays in grudging toleration would quickly reveal problems and possibilities that no one had guessed at in advance. This is a topic on which an ounce of experience is worth a pound of speculation.

Alcohol illustrates how far laws about the currently licit drugs could be tightened without resorting to all-out prohibition, and how many difficult issues are raised when one attempts to interfere with a practice so deeply ingrained in personal habit and social ritual.

The design of a regime embodying the grudging toleration of alcohol also suggests the potential shape of grudging toleration for the second-most-popular intoxicant, marijuana. The potential gains are substantial, but the potential losses are not to be overlooked.

Cocaine illustrates the limits of grudging toleration as a policy approach, and in particular its dependence on a very widespread willingness among the partakers of the vice in question to maintain their consumption within some bounds. I am compelled to admit failure in the attempt to design a program of regulation short of prohibition that would adequately contain the nation's cocaine consumption, and I am skeptical that others will enjoy any better success unless they can invent genuinely new features for regulatory schemes rather than merely rearranging the elements discussed here. The result for heroin and the other opiates and opioids would likely be broadly similar.

### *Alcohol*

The outlines of a system of grudging toleration for alcohol have already been sketched: heavy taxation, strict limits on promotion, a large dose of "negative advertising," a personal license to buy and use alcohol revocable for misconduct, and vigorous enforcement efforts to suppress noncommercial as well as commercial distribution to minors and other unlicensed persons. The likely results, for good and ill, are easy to imagine. On the plus side, there would be a large increase at least in the short run in the revenue from the alcohol tax, (in the range of tens of billions of dollars per year); less drinking by some current problem drinkers, and consequently less intoxicated

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crime and fewer intoxicated accidents; and a reduced (but how greatly reduced?) rate of initiation to drinking, and especially to heavy drinking, among adolescents. On the minus side, we would face the impoverishment of some heavy drinkers who cannot or will not cut back their drinking in the face of higher taxes; the lost benefits of whatever nonproblem drinking is suppressed by higher taxes and tighter controls; the substitution of other mind-altering substances for more-expensive and harder-to-get alcohol; administrative expense and inconvenience and the costs (to the state and to the individuals involved) of punishments imposed on those who violate the rules; and a substantial black market in untaxed alcohol and in alcohol for the unlicensed.

The precise mix of good and bad effects would depend in part on facts about the world (for example, the price-elasticity of demand for drink, the rate of substitution of marijuana for alcohol) and in part on the details of the regulatory regime. The level of taxation is an obvious control variable; less obvious, but not less important, is how aggressive to be in suspending or revoking drinking licenses. The potential customer base for a new bootlegging-and-speakeasy industry depends on the number of involuntarily unlicensed drinkers. The larger the customer base, the larger the enforcement effort required to keep unlicensed dram shops under control. This ought to, but might not, restrain judges or licensing authorities from going overboard in suspending drinking privileges. The place to start is with a relatively small number of repeated drunken drivers and drunken assailants, rather than with the chronic inhabitants of police station "drunk tanks."

In principle, the budget for enforcing the new drinking laws ought to be related to the need for enforcement arising from how tight they are; in practice, there will be a tendency toward a symbolic draconianism, with strong laws undermined by weak enforcement. This is likely to prove the worst possible combination. There is a case to be made for tightening regulations slowly, to avoid setting off a sudden rush of illicit activity that might explode beyond the capacity of the enforcement system to deal with it.

Another design question is whether to impose a quantity limit on monthly alcohol purchases, and if so how tight to make it. Quantity limits would help directly in controlling drinking by heavy drinkers, and indirectly by reducing the problem of leakage to unlicensed

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drinkers. Enforcing such a limit, virtually impossible in the precomputer era, would be no more technically difficult now than enforcing the purchase limits on credit cards. In addition to the obvious problems of privacy, governmental regulation of lifestyle choices in such detail would raise hackles.

In fixing a specific limit, policymakers would confront a tradeoff between tightness and enforceability; as a practical matter, no more than a few percent of the population should find the quantity limit constraining. This suggests what would seem a very loose limit, perhaps four drinks per day (three ounces of absolute alcohol) averaged over a month: about a case and a half of beer a week. After all, the question is about a legally enforced upper limit, not a guideline for moderation. Individuals could also be allowed to select lower limits for themselves, either as protection against their own impulses or to be able to certify their moderation to others, including spouses, employers, and insurers.

A relatively loose top limit would allow for routine hospitality without the need for special exemptions for party-givers. (An alternative would be the creation of a social norm of "bring your own bottle.") More difficult to deal with would be the responsibility of hosts, as opposed to tavernkeepers, to verify that they serve liquor only to licensed individuals. Compliance with this rule would be imperfect, and any vigorous enforcement measures would clearly run into problems of intrusiveness.

The same may well be true of the problem of drinking during pregnancy. Despite the great attention recently lavished on "crack babies," the largest group of profoundly drug-damaged newborns in the United States are the victims of their mothers' alcohol consumption. The problem goes well beyond clinically diagnosed fetal alcohol syndrome to a variety of less obvious developmental deficits.[16] But it is not obvious that coercion is a good way to deal with the issue; privacy, efficacy, and perverse incentives are all problems.

Grudging toleration of alcohol can produce some of the benefits of prohibition with only some of its costs. It cannot put an end to problem drinking, and it will create expense and inconvenience for millions of Americans whose drinking is not a problem to themselves or to anyone else. Alcohol is both a source of pleasure and comfort, sanctioned by long tradition, and a viciously dangerous intoxicant with a substantial risk of addiction; any policy will find itself caught

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between those two realities. Reflecting on the magnitude of the current alcohol problem—90,000 deaths and millions of crimes per year—will help create appropriately modest performance criteria for a new approach. It would take a remarkably poor set of regulations based on grudging toleration to do worse than we have done with virtually unconstrained legal availability.

*Marijuana*

Marijuana is easily the most widely used of the currently illicit psychoactives. While it clearly generates excessive and even compulsive consumption habits in some proportion of its users,[17] carries some health risks (at least those of repeatedly inhaling hot gasses, particulates, carbon monoxide, and "coal tars"), and produces an intoxication dangerous for driving or operating heavy machinery, the vast majority of those who have consumed it have done so without apparent ill effects.[18]

The costs of the current prohibition, including several hundred thousand arrests per year and the creation of an illicit market with approximately ten billion dollars in annual revenue, are very large. Concerns that marijuana may serve as a "gateway" to other psychoactive use are at least partially balanced out by accumulating evidence that, at least in the short run, it and alcohol substitute for one another; if that is true, some of the additional marijuana consumption will replace alcohol consumption, which is at least equally dangerous on average. If any controlled substance is a candidate for grudging toleration, marijuana is.[19] (I leave aside the question of marijuana's medical utility, for nausea control, appetite enhancement, and the control of spasticity and pain. The medical question ought to be resolved independently of the question of licit availability for nonmedical, "recreational" use.)[20]

Since grudging toleration of alcohol would represent a tightening of current controls, while any toleration, however grudging, of marijuana would represent a substantial loosening, the effect of instituting such policies in the two cases would be in opposite directions. Grudging toleration would reduce somewhat the current problem of alcohol abuse, while aggravating the problems associated with its control; by contrast, the severity of the marijuana abuse problem would increase, but the costs of control, especially law-

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enforcement costs, the damage done to users by enforcement action and punishment, and the corruption and violence associated with the illicit market would all diminish to some extent.

Marijuana, along with alcohol and nicotine, forms the entering wedge of drug experience for American adolescents.[21] One argument for changing the current laws is that they have signally failed in making marijuana unavailable to high-school and even junior-high-school students.[22] Worse, marijuana introduces some of them to the opportunities of black-market retailing, which opens up both access to more dangerous substances[23] and to undesirable career patterns. Removing adult marijuana demand from the illicit market will have some beneficial effects in this regard, although it is also to be expected that some juveniles now earning money dealing marijuana will begin to deal something worse, or to engage in theft, as the next-best way of deriving illicit income.

It remains the case that alcohol, which is licit for adults, is much more widely used and abused among adolescents than is marijuana. This suggests that loosening marijuana controls for adults might increase the (already substantial) ease of availability among teenagers (although it also means that substitution away from alcohol would be significant among this group). Thus preventing increased use among adolescents should be one goal in the design of a regime of grudging toleration for marijuana. Presumably, this would mean an age restriction like that now applied to alcohol; the problem would be to make the age restriction for marijuana actually restrict, as the current age restriction for alcohol so signally fails to do.

If all laws regarding marijuana were repealed at once and not replaced, three distinct effects would occur in the conditions of marijuana availability and use: it would be cheaper, it would be easier to obtain, and the enforcement risk associated with using it, and especially using it in public, would disappear. Each of these effects would be expected to result, other things equal, in increased consumption, which is to say an increased number of hours spent intoxicated. Since marijuana already contributes substantially to the nation's experience of intoxication,[24] and especially since most of these hours are accounted for by persons for whom marijuana intoxication is a more-or-less constant state, preventing a major upsurge in consumption, and in particular a substantial increase in

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the number of chronic heavy marijuana users, is a second design criterion.

Other goals would include encouraging those whose use has escaped their voluntary control to quit, if necessary with either professional help or assistance from one of the self-help groups, keeping the incidence of highway and workplace marijuana intoxication down, avoiding a problem with public marijuana intoxication, and reducing the health damage associated with smoking the drug.

The price effect of a complete abolition would be quite substantial. The current black-market price of marijuana (about $300 per ounce for high-potency "sinsemilla") works out to approximately ten cents per milligram of delta-9 tetrahydrocannabinol (THC), the main psychoactive agent. Roughly speaking, ten milligrams of THC produces one person-hour of intoxication, so the current price of a stoned hour is about a dollar. At a guess, the licit price might be one-tenth of that. Since marijuana intoxication is already substantially cheaper per hour than alcohol intoxication, there seems to be no good reason to let the price fall from its current level; anyone for whom the price of getting stoned represents an important economic burden is probably smoking too much.

If the price of licit marijuana were no higher than the price on the black market, the vast majority of users would probably prefer the legal product, which would be of known potency, free of adulterants, and so on. If the licit price were above the illicit price, moonshining would likely pose a more serious problem. Since the remaining illicit marijuana industry would also serve the juvenile market, keeping it small would be essential to the goal of protecting adolescents. Thus the current black-market price seems to be about the right target for tax policy. At that level, governments would be reaping several billions of dollars per year in marijuana tax revenues, money that had previously been going to criminals: not a trivial advantage to set off against the risks of grudging toleration.

High taxes would help reduce very heavy marijuana use, especially since heavy marijuana users would be less able to finance their habits with production or sales in the illicit market. Still, it seems unlikely that the current population of a few million chronic zonkers would shrink; if the total number of users grows once the barriers posed by prohibition are removed, it is probable that some of the additional users will become potheads. In addition, since the legal consequences

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of public marijuana intoxication would be less, we should expect its frequency, and perhaps the rate of disorderly or otherwise noxious behavior, to rise; one consequence of making a substance illegal is to encourage its consumers to behave discreetly to avoid the attention of the police. As we have found with alcohol, disorderly behavior is hard to separate from public intoxication; laws against disorderly conduct are simply too difficult to enforce.

The obvious approach to reducing heavy individual consumption would be to impose a personal quantity limit, as proposed above for alcohol. Administration of such a limit would be easier if purchase were limited to mail-order only. That would also make it possible to administer a system of user licensing (with revocation for intoxicated misconduct or distribution to minors or other unlicensed users) without creating a physical document representing the right to buy marijuana. Again as with alcohol, a quantity limit would reduce consumption by heavy users and at the same time limit leakage from adults to minors, since any one adult would be able to supply only a limited number of teenagers.

The entire system could be administered publicly, or the sellers could be licensees subject to regulation and audit. The shameless promotion of compulsive gambling by state lottery authorities suggests that it may be easier to control a regulated private industry than a public one. In either case, advertising and other promotion should be under strict limits, as securities advertising now is: sellers should be restricted to neutral factual statements about product characteristics, price, and the mechanics of purchase.

Since marijuana is an unprocessed plant material that can be grown indoors or outdoors without any special equipment or skill, a possible alternative to a regulated industry or public monopoly would be to forbid commercial transactions entirely, and simply give adults permission to grow their own. Alaska, where a state court decision effectively decriminalized domestic marijuana growing for personal use, experienced no obvious disaster in the period before a referendum restored full prohibition. Such a system would eliminate the problems of administration, and pressure from an agency or industry to allow promotion, at the sacrifice of tax revenue and of the any control over very heavy personal consumption.

The transition from prohibition to grudging toleration could not be made without risk. Consumption, and consumption-related dam-

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age of all kinds, might suddenly soar, or it might rise slowly but inexorably over a generation, as alcohol abuse did after repeal. In either case, reversing the process of change and returning to prohibition would be formidably hard, since the costs of enforcing a prohibition are directly related to the frequency of the practice to be prohibited. In the very circumstance in which reprohibition would seem most desirable—a huge increase in consumption—it would be least feasible. Our failure to erect a regime of grudging toleration for alcohol, and the huge toll of death and suffering associated with that failure, stand as a warning.

In my view, the costs of maintaining prohibition are sufficiently high, and the damage likely to be done by increased consumption sufficiently modest, to justify accepting the risk. Of course, given the climate of opinion in the United States today, such a proposal has no current prospect of enactment; the mood in parts of Europe may be different.

### *Cocaine*

Cocaine also gives grudging toleration an easy mark to shoot at; the current situation under prohibition is so bad that even a quite poor result could still count as a change for the better. Cocaine-dealing violence is wrecking the inner cities and cocaine law enforcement is bankrupting the criminal justice system, leaving it without the resources to punish violators of other laws. Cocaine dealing plays a substantial role in the shockingly high rate of arrests and convictions among young African-American men.[25] Still, it is worth remembering that any situation, however bad, could get worse.

As the advocates of the repeal or modification of drug prohibitions never tire of reminding us, the measurable health damage done to Americans by cocaine is of trivial size compared to that done by alcohol.[26] This is so, not because cocaine is less physiologically damaging than alcohol, but because it is far less widely used: there appear to be about two million more-or-less frequent cocaine users (weekly or more), and another several million occasional users, in the United States.[27] By contrast, there appear to be more than ten million Americans who fit one definition or another of "problem drinking" (heavy daily drinking or repeated binge drinking) out of a population

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of more than one hundred million who use alcohol at least occasionally.[28]

Cocaine is less widely used than alcohol for many reasons, including tradition and reputation, that might change only slowly if cocaine's legal status were to change. But prohibition has also made cocaine very expensive and at least somewhat inconvenient and risky to obtain. Even after the collapse of cocaine prices during the 1980s, when a flood of cocaine swamped the capacity of the enforcement system, black-market cocaine retails for approximately $100 per pure gram, roughly twenty times the pharmaceutical price. In a genuinely free market in cocaine, a rock of crack would cost about twenty-five cents, as opposed to the current five dollars. Cocaine buyers must also face all the inconveniences of trading in illicit markets: lack of information, the risk of robbery or fraud, uncertainty about product quality, difficulty in locating a seller (more pronounced for inexperienced users and nonresidents of neighborhoods with open drug markets), and the risk of arrest.

Thus the bland assertion of some advocates of cocaine legalization that cocaine consumption might not change if all regulations were removed[29] seems difficult to square with ordinary theories and experience of consumer behavior. When a good gets much cheaper and much safer and easier to obtain, we ordinarily expect that consumers will demand more of it. Thus even if legal availability were accompanied by a complete ban on advertising and other forms of promotion, the expected result would be an upsurge in cocaine consumption.

What regulations, short of prohibition, could be put in place to limit the increase in the population of heavy cocaine users? How successful could one expect them to be?

Cocaine comes in several forms and is taken in several different ways. Traditional use in the Andes involves chewing the coca leaves themselves. The cocaine leaches out of the leaves so slowly that no marked intoxication is experienced. The leaves can also be infused with hot water to make "tea," or *mate de coca*. Again, the subjective effects are far from dramatic. Around the turn of the century, when cocaine was available almost without restriction in the United States, it was consumed most widely in a variety of dilute oral dosage forms, including a wide range of patent medicines, an alcohol-and-cocaine preparation called *Vin Mariani*, and a combination of cocaine, sugar,

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and carbonated water called Coca-Cola. In each case, the dose of actual cocaine is low, and the oral route of administration delivers it to the brain slowly, over a period of several minutes, thus creating a much less dramatic experience than smoking, injecting, or even snorting the pure active ingredient. If all cocaine-taking involved low-dosage oral forms of the drug, cocaine might be no more controversial than its chemical relative, caffeine. It is the administration of the purified chemical, either as a powdery hydrochloride salt, which can be snorted or injected, or as an anhydrous base (freebase or crack) which can be vaporized and inhaled, that has twice given cocaine an evil reputation.[30]

Thus an obvious regulatory approach would be to restrict cocaine to dilute forms designed to be swallowed rather than pure forms to be snorted, injected, or smoked. Even restriction to the hydrochloride powder would represent some progress, since snorting is less prone to generate a powerful habit than smoking,[31] and injection has remained relatively rare. Unfortunately, neither the extraction of pure cocaine from solutions in water nor the conversion of the hydrochloride to the base demand much in the way of equipment, reagents, or chemical knowledge. Thus there is no way to expand availability of the safer forms without making the more hazardous ones easier to get at the same time.

Even if supply regulation could be made effective (for example, by requiring that cocaine preparations include some chemical that would make extraction difficult), the mere existence of a licit market in some forms of cocaine would not by itself eliminate the illicit market in other forms. The regulated cocaine trade could be in addition to, rather than instead of, the illicit one. In that case, there might be social gain in the form of consumers' surplus from the newly-legalized products, but the problem of illicit-market violence that made cocaine legalization a plausible alternative in the first place would remain.

For some users, dilute oral cocaine would substitute for snorting, smoking, or injecting the pure drug. Almost certainly, a large proportion of the customers in any legal cocaine market would be drinking cocaine tea or cocaine tonics. This demand-side effect, substitution, is distinct from the intended supply-side effect of restricting availability to safer forms alone. However, the substitution effect would not be the only one present. Other users, who are now

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afraid to try pure cocaine because of its reputation, deterred by illegality and inconvenience, or simply priced out of the market by illicit-industry markups, would probably try dilute, legal, inexpensive cocaine beverages. Some of them would like the effect enough, or generate a sufficient tolerance for low doses, to want to "graduate" to more powerful forms of cocaine-taking.

Even if slow, low-dose forms gained *relative* market position at the expense of sudden, high-dose forms, the *absolute* number of snorters, smokers, and injectors could nonetheless rise substantially from its current level. It all depends on the relative magnitudes of two opposite effects: the expansion of the total size of the market, and the substitution of weak for strong forms. In any case, given the ease of purification and conversion, the effect will depend primarily on consumers' preferences rather than on official regulations.

That leaves a relatively small vocabulary of possible regulatory measures (taking for granted restrictions on promotion and some sort of official campaign to discourage use or at least to encourage moderation, and assuming that places-and-hours regulations quickly reach the limit of their effectiveness). We could try to manage the price (via taxation or its equivalent in government-monopoly pricing), restrict the quantity available for purchase by any one purchaser, or make the permission to purchase a licensed status.

As with any drug, the decision about price involves a trade-off. Higher prices discourage consumption, but tend to make those who do become heavy users worse off financially. The greater the cash drain on heavy users, the harder on their health and the welfare of their families, and the more of them who will be induced to turn to theft or prostitution as income sources. Lower prices make users better off and reduce their criminal activity, but increase their numbers and, perhaps, the proportion of them who go on to chronic heavy use or repeated binge use.

The current black-market price puts a practical upper limit on the price that could be charged in the newly licit market; otherwise, the promised benefits of the system in eliminating illicit dealing will not materialize.

If the tax level left cocaine near its current black-market price while changes in the laws made it more conveniently available, there appears to be no reason to expect crime by cocaine users (as opposed to dealers) to decrease. On the contrary, not only will any increase in

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the heavy-user population or the quantity per heavy user (due to increased availability and decreased fear of arrest) tend to boost the rates of property crime, but the current population of user/dealers, deprived of the easiest source of illicit income, will begin to look for others. While this loss of dealing income would help reduce the demand for cocaine, it would also tend to increase the rate of theft. Insofar as user/dealers are well armed, at least some of this theft will take the violent form of robbery, either street mugging or store hold-ups. Thus legalization at high prices would substitute robbery for the competitive violence of the current cocaine industry, while increasing other forms of property crime. The magnitudes of the various shifts are difficult to guess.

Even at high prices, the total number of heavy users would tend to grow. That effect would be magnified if taxes were set at levels that created licit prices below the current black-market level. No one has ever produced a persuasive estimate of the price-elasticity of demand for cocaine; the effect of quantity on price (via reduced per-unit costs generated by enforcement) confounds any measurement of the effect of price on quantity.[32] But price is surely an important factor in determining the quantity consumers buy; over the 1980s, as the retail price of cocaine fell from about $800 per pure gram to about $100 per pure gram, the physical quantity consumed rose from about 20 metric tons to about 250 metric tons. Thus a decrease to the pharmaceutical level, which would occur if the newly licit cocaine were untaxed or taxed only as heavily as alcohol now is, could easily give consumption another huge boost; a fivefold increase in consumption is not at all implausible as the consequence of a 95 percent decrease in price. The effect of the introduction of cheap gin into England in the early eighteenth century ought to be a warning.

Thus high taxes to maintain prices would have bad effects on crime, while low taxes would have bad effects on consumption levels. If I had to choose, I would be inclined to favor high taxes, but it isn't an attractive choice to face.

Alternatively, one could let prices fall and rely on a system of quantity restrictions to prevent growth in the chronic or binge-user population. But just as higher-than-current prices would defeat the objective of shrinking the black market, so too would quantity restrictions. Given the extremes of behavior which cocaine-seeking can create, it would require great optimism to assume that making a

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little cocaine available licitly would discourage people from buying more illicitly. On the contrary, the licit market could serve as a promotional mechanism for the illicit one, as some of the users introduced to cocaine under legal conditions found their habits growing beyond legal bounds.

To be enforceable, the quantity limit would have to be set high enough so that most of the current illicit demand could be supplied. But the roughly two million heavy users already account for about 80 percent of the illicit market. Thus a quantity limit so low as to exclude them would leave the black market problem largely unimproved, while a quantity limit high enough to embrace them would allow the new users to develop into problems for themselves, their families, and (at high prices) potential crime victims.

The same problem would apply to licensing cocaine use, as I propose to license drinking. Threatening to withhold cocaine buying privileges from those convicted of property crimes would help prevent a situation in which the revenue collector replaced the illicit cocaine dealer as the final recipient of the proceeds of theft, but carrying out that threat in a sufficient number of cases would help regenerate the black market that would arise to serve unlicensed and over-limit users as well as minors.

Again, if I had to choose, I would impose along with high taxes some sort of quantity limit, but make it generous enough to encompass 95 percent of all users. This would mean supporting a large number of very bad habits, and selling a substantial number of people enough cocaine to kill them. I would also use some sort of licensure to pluck off a few percent of the users who engaged in the most frequent and serious property crime to buy cocaine or assault under its influence. That would leave a significant black market, but probably smaller than the one we now have, and a substantial increase in the number of cocaine users and the health damage due to cocaine, but certainly less than under full unrestricted availability.

The opposite direction would be to "license" use *only* by identified problem users, on the condition that they subject themselves to some form of management by treatment providers, on the model of methadone provision for heroin users. (In Great Britain, where some heroin addicts are maintained on heroin rather than methadone, some cocaine addicts are also offered legal maintenance doses of cocaine.) It is possible that such a cocaine-maintenance strategy could

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be developed for use under US conditions, with some of the same advantages and disadvantages as methadone has, complicated by the extremely short action of cocaine and the frequent dosage that consequently characterizes its use. Such a strategy might help drain off users from the illicit market; if it were made sufficiently inconvenient and humiliating, it might do so without expanding the population of heavy cocaine users. Still, such a treatment option is a far stretch from regulated availability of the drug for use by the general population.

All the choices seem to me bad ones. The combination of cocaine's tendency to induce a strong compulsion to repeated binge use in a substantial proportion of its users with the physical and emotional damage such heavy use can produce makes it an unattractive drug for a regime of grudging toleration. As bad as our current cocaine prohibition is, I cannot invent a version of legal availability for cocaine that wouldn't be worse.

### *Other Drugs*

Examples could be multiplied; the ideal control regimes are nearly as diverse as the categories of drugs to which they might apply. The psychedelics, for example, might best be controlled by requiring that use take place under trained (not necessarily medical) supervision and in physical settings designed to minimize the risk and physical consequences of "bad trips." A design for the regulated availability of substances designed to improve short-term intellectual performance would demand careful consideration of the strategic interactions among academic and professional competitors. Nicotine regulation might appropriately involve the prohibition of cigarettes, except for maintenance supplies for current addicts.[33] But the above probably contains as much speculation as can profitably be offered in advance of more experience.

## THE POLITICS OF GRUDGING TOLERATION

Having, I hope, established that there is a vast territory of potential regulatory schemes between prohibition and the very loose controls we now place on alcohol and tobacco, we can now ask why that should be so. What forces drug policy toward the two extremes and

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away from what might be a sensible center? Alcohol, for example, has gone from being permitted, to being prohibited, to being permitted again, without ever being tightly regulated as proposed here.

Part of the answer may be technological; the information-processing demands of, for example, a quantity-regulation system were simply too great to make such a system feasible before recent advances in computers and telecommunications. But most of it must be ideological and organizational.

To regard a drug as at once safe (for most people under most circumstances) and dangerous (in the wrong hands or at the wrong times and places) puts a strain on individual and collective tolerances for cognitive dissonance. Nor is it comfortable for citizens and officials to think about the dangers of their own habits; it is far easier to locate the "drug problem" entirely in the other person's (or class's, or generation's) drugs. That is what creates controversy around what ought to be obvious propositions, such as "alcohol is a drug" or "nicotine is highly addictive."

Moreover, the strain between drug prohibition and ideological opposition to state interference in private choices can be relieved by asserting that any use of the banned drugs is harmful in itself, and that therefore no valuable liberty is denied by their prohibition. Such a claim would be much harder to square with a program of grudging toleration. In particular, any system of personal licensing and quantity limitation would require "bureaucracy" and "red tape." By contrast, a strict prohibition, though far more restrictive, does not require citizens to apply to officialdom for permissions of various kinds and generates no lists of those who engage in lawful but potentially embarrassing activity.

Any regulatory regime creates either a public monopoly or a regulated industry. The employees of either one will not be happy regarding themselves as purveyors of a vice, and as servants of either taxpayers or stockholders they will have every incentive to increase revenues by increasing the volume of consumption. Thus a program of strict regulation short of prohibition may not be stable over time. The state lotteries, with their relentless promotion, serve as a bad example.[34]

Finally, I must emphasize that grudging toleration does not hold out the prospect of a "solution" to the drug problem. Even for those substances to which it could be successfully applied, it would leave us

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with a mix of abuse costs and control costs. While one could hope that those costs would be, in sum, smaller than those we face under either prohibition or unrestricted legalization, they will not be close to zero. The potential for drug abuse appears to be a fundamental characteristic of the interaction of various chemicals with the human mind and body, and no combination of laws and programs will make it go away.

Nor is grudging toleration the best regime for all drugs. If it is not possible to create a control system sufficiently tight to avoid massive abuse but sufficiently loose that the vast majority of participants can be induced to observe it, grudging toleration fails. This, I have argued, is likely to be the case for cocaine under current conditions in the United States. Since cocaine is by any reasonable measure the most important among the nation's current illicit drug problems, the inapplicability of grudging toleration to the cocaine situation makes the concept less important than it would otherwise be. If I am right about this, then the legal and enforcement machinery of drug prohibition must remain in place even if we decide to cease applying them to some of the currently illicit drugs. Grudging toleration may be a good idea; a panacea it is not.

But that does not mean that our current policies toward cocaine are the ideal ones, or that improvements within the ambit of current laws are impossible. On the contrary, it is easy to list several major reforms within the enforcement sphere alone: shifting resources from high-level to retail-level enforcement, with an emphasis on low-arrest strategies; the abolition of long mandatory minimum sentences except for true "kingpins" and those who engage in violence in connection with dealing; and a program of coerced abstinence, backed by random testing and sanctions, for cocaine and heroin users who are also drug dealers, muggers, burglars, or assailants.[35]

It is regrettable that criticism of the excesses of the war on drugs has become identified with proposals for some form of legalization. This allows the drug warriors and their critics alike to duck the tough practical issues. The abolition of drug abuse, and of the drug laws, are alike utopian dreams. It is time to wake up.

ENDNOTES

[1]Many of the ideas in this essay were developed in collaboration with Aaron Saiger. See Kleiman and Saiger, "Drug Legalization: The Importance of Asking the Right

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Question," *Hofstra Law Review* 18 (3) (Spring 1990): 527–65. Credit is also due to Lowry Heussler, who greatly improved the prose, and David Osborne, who found the references.

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[3]Office on Smoking and Health, *Nicotine Addiction: The Health Consequences of Smoking* (Rockville, Md.: Department of Health and Human Services, 1988); Mark H. Moore and Dean R. Gerstein, eds., *Alcohol and Public Policy: Beyond the Shadow of Prohibition* (Washington, D.C.: National Academy Press, 1981); Willard G. Manning, Emmett B. Keeler, Joseph P. Newhouse, Elizabeth M. Sloss, and Jeffrey Wasserman, "The Taxes of Sin: Do Smokers and Drinkers Pay Their Way?" *Journal of the American Medical Association* 261 (11) (17 March 1989): 1604–609.

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[6]Peter K. Levison, Dean R. Gerstein, and Deborah R. Maloff, eds., *Commonalities in Substance Abuse and Habitual Behavior* (Lexington, Mass.: D.C. Heath and Company, 1983).

[7]John Kaplan, *The Hardest Drug: Heroin and Public Policy* (Chicago: The University of Chicago Press, 1983), 16–18.

[8]See Thomas Szasz, *Our Right to Drugs* (New Haven, Conn.: Praeger, 1992).

[9]Michael O'Hare, "A Typology of Governmental Action," *Journal of Policy Analysis and Management* 8 (4) (1989): 610–72; Charles L. Schultze, *The Public Use of Private Interest* (Washington, D.C.: Brookings Institute, 1977).

[10]Niccolo Machiavelli, *The Discourses on Livy,* Bernard Crick, ed. (Baltimore, Md.: Penguin Books, Inc., 1976), Book I, Discourse 17, 157–60.

[11]Manning, et al., "The Taxes of Sin: Do Smokers and Drinkers Pay Their Way?"

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[12]Mark A.R. Kleiman, *Against Excess: Drug Policy for Results* (New York: Basic Books, 1992), 244–49.

[13]Phillip Cook and George Tauchen, "The Effect of Liquor Taxes on Heavy Drinking," *Bell Journal of Economics* 13 (1982).

[14]Preliminary data from Lloyd D. Johnston, Jerald G. Bachman, and Patrick M. O'Malley, *Monitoring the Future 1990* (Ann Arbor, Mich.: Institute for Social Research, 1991), Table 9.

[15]Kleiman, *Against Excess,* 211–12.

[16]Ruth E. Little, R.L. Asler, Paul D. Sampson, and J.H. Renwick, "Fetal Growth and Moderate Drinking in Early Pregnancy," *American Journal of Epidemiology* 123 (1986): 270–78; Ann P. Streissguth, Helen M. Barr, et al., "Attention, Distraction, and Reaction Time at Age Seven Years and Prenatal Alcohol Exposure," *Neurobehavioral Toxicology and Teratology* 8 (1986): 717–25; Daniel Coleman, "Lasting Costs for Children Are Found From a Few Early Drinks," *New York Times,* 10 March 1991.

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[18]Mark A.R. Kleiman, *Marijuana: Costs of Abuse, Costs of Control* (New Haven, Conn.: Greenwood Press, 1989), 3–22; Kleiman, *Against Excess,* 253; Institute of Medicine, *Marijuana and Health* (Washington, D.C.: National Academy Press, 1982).

[19]Kleiman, *Against Excess,* 277–80.

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[24]Kleiman, *Against Excess,* 254.

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[26]National Institute on Alcohol Abuse and Alcoholism, Sixth Special Report to the US Congress on Alcohol and Health (Rockville, Md.: Department of Health and Human Services, 1987), Table Y, p. 6; Kleiman, *Against Excess,* 290–91.

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[34]Charles T. Clotfelter and Philip J. Cook, *Selling Hope: State Lotteries in America* (Cambridge, Mass.: Harvard University Press, 1989).

[35]For these and other practical suggestions, see Kleiman, *Against Excess.*

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We are in the midst of the largest war on drugs in our history, which gives unprecedented importance to enforcement and interdiction. Yet drug addiction and drug related crime continue to rise. At the same time, many Americans are turning away from marijuana and cocaine because they believe these drugs are harmful. The greatest declines in drug use are occurring among the better educated and affluent, while addiction is growing among the poor, the disadvantaged, and racial minorities. In 1991, more than a third of all Americans who reported using drugs at least once a month were Black or Hispanic. As this divide deepens, there is a real danger that law enforcement will become even more dominant.

Record antidrug expenditures—which in 1992 alone will cost federal, state, and local governments over $40 billion—have not bought victory. We now have the highest rate of addiction in our history, exceeding even that at the turn of the century, when opiates, cocaine, and marijuana were legally marketed. We also have the highest rate of imprisonment in the world, largely because of drug related crime.

We do not need a larger drug war which pours even more resources into trying to seal the nation's borders, eradicate foreign drug crops, and lock up addicts. We need an entirely different approach built on what we have learned about reducing drug abuse and drug crime. The most promising strategies are coming not from Washington and state capitols, but from communities working to find new solutions to their drug problems. They are moved by the simple but critically important discovery that the answers to America's drug problem lie here at home. They recognize, too, that no one can escape the myriad effects of drug abuse on our families and society, and that they must therefore "take ownership" of this problem.

Mathea Falco

From *The Making of a Drug-Free America: Programs that Work, October 1992*

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*Ethan A. Nadelmann*

# Thinking Seriously About Alternatives to Drug Prohibition

FOUR YEARS AFTER THE NOTION of drug legalization reemerged into public view, the time has come to step back and evaluate what it is all about and where it should be headed.[1] I cannot help but write as one who has become closely identified with the notion, but I also write as one who has tried to step back from the debate over drug legalization and analyze critically its contributions, missteps, and potential to beneficially redirect drug control policies. My principal interest lies not in the debate itself but in the future of psychoactive drug use and drug control policies in the United States and abroad. This article is thus not a response to the many critics of drug legalization, nor even a dispute with those who have favored the notion with somewhat different arguments and suppositions. It generally refrains from repeating the well documented costs of drug prohibition or the reasons why we need to consider alternative approaches.[2] And it pays scant attention to the political context of the debate or the political future of drug control policy. Its objective, rather, is to create and advance a more informed and sophisticated public discourse about alternatives to drug prohibition—one that breaks free from the intellectual and moralistic confines of contemporary prohibitionist norms.[3]

My specific objectives are fourfold. The first is to identify and examine the essential differences that separate those in the reasonable middle ground of the debate. The second is to offer new ways of thinking about radical alternatives to current drug prohibition policies, to identify the sorts of questions that must be asked, and to

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suggest how they might be addressed. The third is to provide evidence in support of the proposition that even a radical decriminalization of drug prohibition will not result in the sorts of dramatic increases in substance abuse that self-identified critics of drug legalization fear. And the fourth is to propose a drug regulatory model that eliminates many of the worst consequences of drug prohibition without reproducing the unfortunate consequences of our alcohol and tobacco control policies.

Many of the ideas and arguments presented in this paper were proposed and developed in meetings of the Princeton Working Group on the Future of Drug Use and Alternatives to Drug Prohibition. This group, composed of eighteen scholars representing more than a dozen disciplines, is currently pursuing each of these four objectives. This article should thus be read as a synopsis of a collaborative work-in-progress, the final version of which will be completed in late 1993. I anticipate that many of the ideas advanced below will be revised and refined as the working group proceeds.

## THE "LEGALIZATION" LABEL

To legalize or not to legalize? That, as two pairs of drug policy skeptics have recently written, is not really the right question.[4] The appropriate question is much broader, and it is one that incorporates the "legalize or not" question with respect to particular psychoactive drug products: What, simply stated, are the best means to regulate the production, distribution, and consumption of the great variety of psychoactive substances available today and in the foreseeable future? For a variety of reasons, the efforts of myself and others to answer that highly complex question have been captured by the label of "legalization." The term itself proved immensely successful in drawing the attention of tens of millions in the United States and elsewhere to what was at once a radical sounding but quite sensible critique of American drug control policies. But it exacted a stiff price with its implication that the only alternative to current policies was something resembling current US policies with respect to alcohol and tobacco. Few of those publicly associated with legalization in fact advocated such an alternative, but the misimpression has stuck in the public mind.

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Legalization has always meant different things to different people. From my perspective, it has been first and foremost a critique of American drug prohibitionist policies which stresses the extent to which most of what Americans commonly identify as part and parcel of "the drug problem" are in fact the results of those policies. The failure of most Americans to perceive the extent and content of this causal relationship, and to distinguish between the problems that stem from the misuse of drugs per se and those that stem from drug prohibitionist policies, remains the single greatest obstacle to any significant change in American drug control policies. The recognition of this causal relationship does not, it should be stressed, lead automatically to a public policy recommendation that all of drug prohibition be abandoned. But it does suggest that alternative policies less dependent upon prohibitionist methods are likely to prove more effective.

Legalization also implies a set of policy objectives at odds with the government's proclaimed objectives of fighting a war against drugs and creating a drug-free society. Any drug control strategy, I and others have argued, should seek to minimize both the negative consequences of drug use and the negative consequences of the policies themselves. This is as true of public policies with respect to alcohol, tobacco, and caffeine as it is of policies directed at limiting the misuse of cannabis, cocaine, amphetamine, opiates, hallucinogens, and all other drugs. It is imperative, for instance, that any drug control policy distinguish among casual drug use that results in little or no harm to anyone, drug misuse that causes harm primarily to the consumer, and drug misuse that results in palpable harm to others, and then focus primarily on the last of these, secondarily on preventing the misuse of drugs, and little if at all on casual drug use. It is also imperative that any drug control policy be assessed not only in terms of its success in reducing drug abuse but also in terms of its direct and indirect costs.

Implicit in the legalization critique of American drug control policies are in fact two different types of arguments. At one level, it points out the ways in which drug prohibition per se is responsible for many drug-related problems. By criminalizing the production, distribution, and use of particular drugs, drug prohibition fundamentally transforms the nature of the drug markets, the ways in which people consume drugs, the lenses through which much of society

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views the drug problem, and the range of policies deemed appropriate for dealing with drug abuse. On another level, however, the critique advances a far more modest claim, which is that there are better and worse types of drug prohibition, with the Dutch "harm reduction" approach epitomizing the former and the American "war on drugs" the latter. Indeed, for many of those characterized as advocates of drug legalization, the Dutch model offers an alternative that is preferable not only to current US policies but also to the extreme libertarian model. The ideal set of drug control policies, from this perspective, can be found somewhere between the Dutch example and the libertarian model.

The harm reduction (or harm minimization) approach emerged in the Netherlands and Great Britain during the 1970s and early 1980s. It has since become increasingly influential both in those countries and in other parts of Europe and Australia as public health and other officials have recognized the need for more innovative and less punitive policies to stem the transmission of the HIV virus by illicit drug users.[5] Harm reduction policies seek to minimize the harms that result from illicit drug use. Rather than attempt to wean all illicit drug addicts off drugs by punitive means, harm reduction policies begin with the acknowledgement that some users cannot be persuaded to quit. These policies then seek to reduce the likelihood that they will contract or spread diseases such as hepatitis and AIDS, overdose on drugs of unknown purity and potency, or otherwise harm themselves or others. Proponents of harm reduction policies typically favor an assortment of drug treatment programs including the use of methadone and other maintenance programs. They insist on the need for needle exchange programs. They recommend public health and community outreach efforts to maintain contact between health service providers and illicit drug users. And they demand that drug policies acknowledge, both in law and policy, the human rights of drug users. Also implicit in most harm reduction approaches is the notion of "normalization," which posits that the harms associated with illicit drug use are best minimized by integrating drug users into normal society rather than isolating them in separate clinics, programs, markets, and neighborhoods.[6]

The relationship between the harm reduction approach and the notion of drug legalization remains ambiguous. Some proponents of the harm reduction approach vigorously oppose any broader trend

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toward disassembling the drug prohibition system. They are quick to point out that much of the opposition they have encountered stems from fears and perceptions that the harm reduction approach represents no more than a stepping stone to legalization. Others insist that a harm reduction approach taken to its logical and sensible conclusion would more closely resemble a legal regulatory regime than the current prohibition system. Any harm reduction approach, they argue, must reduce not just the harms to users but also the many other negative consequences of drug prohibition: the violence that accompanies illicit drug markets; the corruption of public officials; the de facto subsidy of organized crime; the incarceration of hundreds of thousands of people; the deprivation of individual liberties; and so on. All agree, however, that modest efforts to reduce the negative consequences of status quo policies are better than no efforts whatsoever.

## LEGALIZERS, PROHIBITIONISTS, AND THE COMMON GROUND

The basic analysis advanced by most "legalizers" is remarkably similar to that advanced by those who have appeared as the most sensible, progressive, and nonideological among the prohibitionists. Both generally agree on the basic diagnosis of American drug prohibition, on the need to assess drug policy options in terms of their costs and benefits, and on the set of objectives noted above. The "progressive prohibitionists" largely acknowledge that casual drug use is not a problem in and of itself, and the legalizers grant that some policies designed to reduce overall levels of drug use may be effective in reducing the overall negative consequences of use. There is a shared recognition that many dimensions of the American war on drugs represent a form of overkill, that more modest criminal justice measures can accomplish the same objectives as successfully as the harsher measures, and that a more vigorous adherence to public health precepts and objectives will result in a superior mix of drug control policies. Both further agree that a dramatic expansion in the availability of drugs in society will likely increase the cumulative consumption of drugs. And both agree that it is important to draw distinctions among different drugs, and among different formulations of the same drugs, in designing drug control policies. Stated other-

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wise, few in either camp believe that marijuana, or coca tea, should be treated the same as crack cocaine.

This common ground is fundamentally at odds with the views expressed by the more conservative and reactionary prohibitionists. Articulated most vigorously by President Bush's first Drug Czar, William Bennett, this perspective has demonstrated no interest whatsoever in analyses of costs and benefits or in the need to minimize the negative consequences of drug control policies. Casual use of illicit drugs has been depicted as an immoral form of activity as well as a dangerous source of contagion requiring the treatment of users.[7] Social science research and public health precepts are of value only insofar as they conform with their ideologically based assumptions and policies. There is, in short, no room for dispassionate dialogue concerning any policy alternatives that do not appear tougher than what has been tried before.[8] Combining a penchant for punitive sanctions with a view of drug use best described as "pharmacological Calvinism,"[9] the reactionary prohibitionists have insisted that the only legitimate objective of drug control policy must be the elimination of illicit drug use.

The common ground is also at odds, albeit not quite so fundamentally, with the conservative libertarian perspective on drug control.[10] For those libertarians who believe as an absolute matter of principle in the sanctity of individual sovereignty over property and the freedom of contract, no governmental controls on the commerce in drugs are acceptable no matter what the consequences. Other libertarians are more utilitarian in their thinking, placing their faith in the free market and assuming that the dual policy objectives would best be accomplished in the absence of governmental interventions. Less committed libertarians start from the same assumptions about the magic of the free market but acknowledge that modest governmental controls, particularly truth-in-advertising and labelling requirements, may be necessary to correct for the excesses and abuses that the free market invites. All of these libertarians tend to support the more civil libertarian commitments to individual privacy and freedom in the choice of one's lifestyle—although they insist that freedom of contract includes the freedom of employers to insist upon drug testing as a condition of employment. Civil libertarians, by contrast, tend to regard the freedom of contract with less deference than the right to privacy. They are more apt to speak of a right to consume drugs,[11]

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and are more likely to integrate considerations of social justice and public health into their principles and policy calculations.

Putting aside the perspectives of the reactionary prohibitionists and the hardcore libertarians, there are two principal differences among the progressive legalizers and the progressive prohibitionists. The first reflects disagreements as to the weight that should be accorded to such values as individual liberty, privacy, and tolerance in calculating the costs and benefits of different drug control policies.[12] Most legalizers weigh these values heavily, with the more committed civil libertarians regarding them as absolutes that cannot be compromised and other progressive legalizers perceiving them as highly important but not inherently immune to some restraints. At the very least, most legalizers insist, the possession of modest amounts of drugs for personal consumption should not be the subject of criminal laws. The progressive prohibitionists are sympathetic to such values but accord them much less weight, both because they perceive them as undermining efforts to reduce drug abuse and because they are more willing to defer to majoritarian opinion in defining and weighting them. Confronted with potential trade-offs between levels of drug abuse and levels of coercion directed at drug users and sellers, most legalizers are willing to concede modest increases in drug abuse levels in return for reductions in the numbers of those punished for using and selling drugs. Progressive prohibitionists, by contrast, are far more willing to limit individual liberty to the extent they perceive a potential gain in public health.

The second major difference of opinion involves the assessment of the vulnerability of the American population to the substantial increases in drug availability that would follow from any of the more far reaching drug legalization schemes. Where most prohibitionists can envision the possibility of a fiftyfold increase in the number of people dependent upon cocaine, and conclude that the future of the nation might well be at stake if cocaine were made as available as alcohol, most legalizers regard such estimates and predictions as the unsubstantiated folly of doomsayers.[13] Both agree that substantial research is required to better estimate this vulnerability, but the wide disparities are primarily a reflection of visceral fears, beliefs, and instincts regarding individual and collective human nature in the context of American society. Whereas most legalizers perceive, both

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instinctually and intellectually, ample evidence of a fundamental societal resilience, most progressive prohibitionists share with their more reactionary allies a fundamental pessimism regarding the susceptibility of American society to a dramatic liberalization of drug availability.

The roots of this viscerally based debate can be found in a related difference of opinions regarding the balance of power between psychoactive drugs and the human will. Prohibitionists typically see the balance favoring the former, with its potential to disrupt and destroy the lives of consumers. Legalizers, by contrast, emphasize the latter, with its assumption that the balance of basic human desires in most people effectively limits the destructive potential of drugs. For most prohibitionists, the relevant evidence includes the worst case examples of drug addiction and other abuse, the experiments on captive rats, monkeys, and other nonhuman animals to determine the addictive liability of different drugs, and the biological evidence of withdrawal symptoms in human beings following sustained consumption of particular drugs. Most legalizers, by contrast, focus on the less dramatic but more abundant evidence of casual and controlled drug use, insist that the "set and setting" of drug use are at least as important as the drug itself in determining whether a person becomes a drug abuser, and see the animal studies and biological evidence as less significant than the abundant historical, cross-cultural, and contemporaneous evidence of individual and societal resilience vis-à-vis all psychoactive drugs. ("Set is a person's expectations of what a drug will do to him, considered in the context of his whole personality. Setting is the environment, both physical and social, in which a drug is taken.")[14] Many prohibitionists seem to see some psychoactive drugs as possessed of powers akin to those of the Sirens whose alluring voices no man could resist. Most legalizers, by contrast, perceive such a notion as absurd. They find more persuasive the substantial evidence that most people (including children), given sufficient information, are unlikely to use a drug in the first place, that most of those who do try a particular drug tend either to stop shortly thereafter or to use it in moderation, and that even most of those who become addicted to a drug or otherwise misuse it, ultimately moderate or stop their use.

These differences, however, still leave abundant room for common ground on how drug control policies can be reformed in the short

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term. For even though the progressive prohibitionists share with their more reactionary allies a deep seated fear of greater drug availability, they lack the reactionaries' political and moral commitments to repressive policies. And even though most legalizers feel substantial revulsion for the more punitive prohibitionist measures, they recognize both the inevitability of, and the need for, some criminal justice accompaniments to any regulatory regime. The public health model, with its emphasis on reducing morbidity and mortality, appears to provide something of an ideologically neutral set of guidelines and parameters for working out a preferable set of drug policies—although legalizers are wary of the totalitarian potential of a public health model taken to its logical extreme. Both legalizers and most progressive prohibitionists also perceive merit in the harm reduction policies developed by the Dutch as well as local authorities in England and Australia—even if they differ as to the extent to which those policies could be adapted to the American environment.

There is also a shared assumption, from which only the most libertarian of the legalizers dissent, that government does have an important role to play in shaping and improving the lives of its citizens. Where all sides differ is in their view of the appropriate means by which government should pursue this, with the progressive prohibitionists viewing criminal justice and other coercive mechanisms as perfectly acceptable and often efficient means and the progressive legalizers favoring less coercive measures ranging from education and voluntary treatment programs to broader provision of social services. There also is something of a consensus that the top priority of drug control programs should be to minimize the harm that drug users do to others, with the secondary priority involving the more traditional public health objectives of minimizing the harm that drug users, and especially children, do to themselves. But underlying even this consensus are differing assumptions regarding the appropriate reach of social control measures designed to detect and curtail the illicit use of drugs. Thus even among those who identify themselves as proponents of a "public health" approach to the drug problem, there are some who sympathize deeply with the legalizers but prefer to keep their more ideological, liberty-based, values out of their analyses, and others who see criminal justice sanctions and civil commitment laws as useful means with which to coerce drug users into treatment programs.[15]

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The fact that legalizers and progressive prohibitionists have so much in common is significant for a number of reasons. First, it suggests that there is a basic framework of analysis, predicated upon systematic assessment of costs and benefits, that is regarded as intellectually legitimate by all serious analysts of drug control policy. The fact that the evaluation of the costs and benefits varies greatly depending upon one's ethical values and ideological assumptions does not negate this. Second, it suggests that the current framework and direction of drug prohibition policies in the United States are fundamentally at odds with any conceivable policy predicated upon either public health precepts or notions of harm reduction. Indeed, the only way to explain and justify many current policies is by reference to the fears, prejudices, and primitive moralisms of those who have transformed drug control policy into a modern version of an authoritarian crusade. Third, it suggests that the debates *among* the legalizers over the design and evaluation of alternative drug control policies may well be of interest to many who share neither all of the legalizers' values nor their visceral confidences.

## THE DRUG POLICY SPECTRUM

It should be clear by this point that drug legalization and drug prohibition do not represent simply radical alternatives to one another and that there is no single version of either one. Virtually all drug control policies incorporate elements of both prohibition and legal availability. Alcohol, for instance, is regarded as a legal drug but it is illegal to sell it to anyone under the age of twenty-one, illegal to drive while under its influence, and illegal, in many states and localities, to consume in public or to sell or buy except from government-controlled or government-licensed outlets. Many of the same prohibitions increasingly apply to cigarettes and other tobacco products. Nicotine gum, which is substantially less harmful than smokeable tobacco, cannot even be purchased over-the-counter. Cocaine and most opiates are typically regarded as illegal drugs, but both are prescribed by doctors, the former for nasal and dental surgery as well as (in a few cases) treatment of pain, the latter as a prescribed treatment for pain or, in the case of methadone, as an authorized alternative to illicit heroin. The distinction between legal regulatory policies and prohibitionist policies becomes even more

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obscure when one surveys the broad spectrum of alcohol control policies that have been employed around the world during the past century; the same is true of opiate control policies and, to a lesser extent, public policies directed at the control of most other psychoactive drugs.

Nonetheless, one can distinguish between prohibition and legalization in at least two significant respects. The sharper distinction concerns whether or not a drug can be purchased over-the-counter, which is to say that it can be purchased legally by adults without first obtaining permission from a government agency or government-licensed agent such as a doctor. The more ambiguous, but equally important, distinction is between those policies that rely primarily on criminal sanctions to control the misuse of drugs and those that rely primarily on the informed choices of citizens as shaped by public health policies, regulatory structures, and honest drug education.

It can be useful to think about alternative drug control policies as arrayed along a spectrum, with the strictly prohibitionist and highly punitive at one end, the unregulated free market at the other end, and a wide array of regulatory policies in the middle. It requires minimal insight, moreover, to recognize that any drug control policy driven principally by public health considerations and stripped of the moralistic and authoritarian impulses that motivate contemporary policy would have little use for many of the more punitive measures in evidence today. The hard questions begin when values such as privacy, tolerance, and a presumption against imprisonment for most nonviolent drug-related activities are factored into the analysis of costs and benefits. They become even tougher to answer the further we venture along the policy spectrum into the relatively unknown territory of untested regulatory mechanisms and over-the-counter availability of drugs that currently can be purchased, if at all, only with a doctor's prescription.

Why venture into the unknown terrain of a truly nonprohibitionist drug policy given both the difficulties of evaluating the consequences of such a policy and the unlikelihood of it being favored by a majority of Americans within the foreseeable future? There are four reasons, each of which are developed below. First, only such a policy can dramatically reduce the many negative consequences of drug prohibition. Second, it helps us to address fundamental questions about the basic need for a drug prohibition system—in particular long

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unexamined assumptions about the differences between psychoactive substances and other consumer items as well as the vulnerability of the population to a broader availability of psychoactive drugs. Third, drug policy is one area in which libertarian assumptions regarding the magic of the free market may be more right than wrong. And fourth, the future may bring both new drugs as well as new ways of altering our states of consciousness that are not readily susceptible to governmental controls and that transform the ways in which Americans think about drugs and consciousness alteration.[16]

Thinking seriously and systematically about radical alternatives to current drug prohibition policies requires a degree of intellectual "stretching" that is relatively unusual in policy analysis generally and virtually unknown in the specific case of drug control policy analysis. This stretch is best accomplished by asking two complementary questions: How do we best maximize the benefits of the free market model and minimize its risks? And how do we best retain the advantages of drug prohibition while minimizing its direct and indirect costs? This stretch can be visualized by focusing on the extremes of the drug policy spectrum, with the free market at one end and contemporary American drug prohibition near the other end, and then trying to stretch each toward the other by applying notions of harm minimization to each.

The stretch from contemporary prohibition is, of course, the easier and more familiar one. It begins with a known quantity, the status quo, which is far easier to evaluate than theoretical alternatives—even if many causal relationships resist precise identification. The tendency of policy analysts and policymakers to focus on options that fall within or close to the realm of politically acceptable options means that far more thought and discussion have been devoted to the more modest revisions of current prohibition policies. Many of the initial steps that one can envision already have been taken in the Netherlands, England, Australia, and elsewhere. And even many of the steps that might be taken beyond what is currently happening abroad still require no radical changes in either the structure or the mechanisms of prohibition.

The further one stretches from the contemporary prohibition model, however, in terms of reducing criminal justice and other coercive controls on the distribution of drugs, the more difficult it becomes to evaluate the consequences. It is, for instance, not that

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difficult to estimate the consequences of making marijuana, heroin, and other strictly prohibited drugs available by prescription, or of legalizing the sale and possession of syringes and other drug paraphernalia, or of extending the limited decriminalization of marijuana possession enacted by eleven states during the 1970s to the entire country. There are powerful reasons to believe that each of these policy changes would substantially reduce the undesirable consequences of drug prohibition and present only modest risks in terms of public health. But it is quite another thing to estimate the consequences of making cocaine, amphetamine, morphine or heroin more readily available to registered addicts, and surely an even greater intellectual challenge to evaluate the consequences of making these drugs legally available over-the-counter. That challenge cannot be met, I suspect, by taking contemporary prohibition, and the patterns of drug use that have emerged under it, as the starting reference points.

## EVALUATING THE "SUPERMARKET" MODEL

Starting from the alternative extreme of the policy spectrum, the free market, obliges us to focus on the question that lies at the heart of the debate between legalizers and prohibitionists of all stripes: What would be the consequences for American society of having virtually no drug control policy whatsoever? Imagine, for instance, that Congress passed a law granting the freedom of drug consumption and even production and distribution the same legal protections as the rights of freedom of speech, press, religion, and assembly. And imagine that "supermarkets" existed all around the country in which drugs of every variety could be purchased at prices reflecting nothing more than retailers' costs plus reasonable profit margins and sales taxes. This is, of course, the nightmare scenario portrayed by the opponents of legalization—even if it is not the policy favored by virtually any of those identified as proponents of legalization apart from the most hardcore libertarians.[17] But it also bears a close resemblance to the relatively free market in drugs found in late nineteenth-century America—a period characterized by a fairly high rate of opiate and other drug consumption but dramatically fewer drug-related problems than we see today.[18]

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The great advantage of this model is that it eliminates virtually all of the direct and indirect costs of drug prohibition: the many billions of dollars spent each year on arresting, prosecuting, and incarcerating hundreds of thousands of Americans, the diversion of scarce governmental resources from dealing with other, more immediately harmful, criminal activities, the tens of billions of dollars earned each year by organized and unorganized criminals, much of the violence, corruption and other criminal activity associated with the illicit drug markets, the distortion of economic incentives for inner-city residents, the severe problems posed by adulterated and otherwise unregulated drugs, the inadequate prescription of drugs for the treatment of pain, the abundant infringements on Americans' civil liberties, and all the other costs detailed in the extant literature on drug prohibition and legalization.

The great disadvantage of the supermarket model is its invitation to substantial increases in both the amount and the diversity of psychoactive drug consumption. What needs to be determined as best as possible are the magnitude and nature of that increase and its consequences. Among the more explicit assumptions of the legalization analysis is that the vast majority of Americans do not need drug prohibition laws to prevent them from becoming drug abusers. By contrast, prohibitionists typically assume that most Americans, and at the very least a substantial minority, do in fact need such laws—that but for drug prohibition, tens of millions more Americans would surely become drug abusers. The supermarket model provides no immediate insights into which perspective is closer to the truth, but it does suggest two important approaches on analyzing the implications of a free market.

First, it is imperative that analysts broaden their horizons to examine not just potential changes in the consumption of drugs that are currently illicit but changes in the cumulative consumption of all psychoactive substances. Virtually all human beings consume psychoactive substances. Alcohol and caffeine are certainly the two most common in the United States today, followed by nicotine, marijuana, and a variety of the more popular prescription drugs used to alleviate feelings of depression and anxiety. With the notable exception of alcohol, which has retained its preeminent position throughout the history of American psychoactive drug consumption, all other drugs have witnessed substantial changes in their levels of consumption.

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Some of these changes have been a result of changes in drug laws. Others have reflected the emergence of new drugs, or new formulations of familiar drugs, as well as changes in medical prescription practices, new marketing techniques, changing fads and fashions in recreational drug usage, and broader changes in popular culture as well as particular subcultures. The notion of a truly free market in drugs obliges us to consider what would happen if alcohol, nicotine, and caffeine no longer were artificially favored over other drugs by virtue of their legal status. One strong possibility is that other drugs—including some that are common in other societies, some that were once more popular in America than they are today, and some that have yet to be designed or discovered—would compete with and substitute for those drugs that are most familiar to Americans today.

Indeed, one of the silver linings on the black cloud of greater drug use under different legalization regimes is the prospect that less dangerous drugs would drive out the more dangerous ones. By most accounts, alcohol and tobacco represent two of the most dangerous drugs that have ever entered into common usage in human society. Between them, they present a high proportion of all of the harms associated with other drugs that have experienced widespread usage at one time or another. Tobacco, especially when consumed in the form of cigarettes, is both highly addictive and readily identified as a cause of cancers, cardiovascular diseases, and other ills. Alcohol can be highly addictive for some users; consumed in abundance, it can cause death by overdose in the short-term and cirrhosis of the liver and other diseases in the long-term. It also is strongly associated with violent behavior and accidental injuries in a great variety of societies. There is no reason to assume that their predominant position in the hierarchy of favored psychoactive substances will persist forever, and good reason to believe that the desirable functions they serve can be replaced by other substances that pose far fewer dangers to the health of consumers in both the short and long-term. The same may well be true of relatively less dangerous drugs, such as caffeine, which might well lose out in the competition to other psychoactive substances, such as low potency coca and amphetamine products, that may improve performance more effectively with even fewer negative side effects.

The possibility of dramatic substitution effects under a free market regime suggests that the most important issue in evaluating the

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consequences of such a model is neither the overall magnitude of drug consumption nor the number of drug users under such conditions, but rather the magnitude of the negative consequences that would result: the immediate effects of drug misuse on the health and behavior of the user; the debilitating effects of sustained misuse; and the deadly effects of sustained consumption. Each of these effects may also be of consequence for nonusers ranging from those who love or live with drug abusers to those who depend upon them in the workplace to those who encounter them on the roads. The evaluation of these consequences, and the assessment of which are more or less serious, inevitably involve ethical judgments. But is important to recognize that public policy can seek to shift patterns of drug use and even abuse in safer directions by favoring drugs, sets, and settings that cause less harm to users and others. It is, in short, possible for the undesirable effects of drug use to decrease significantly even as the amount and diversity of drug consumption increase substantially.

Indeed, if we really seek to be truly objective in our assessments, what needs to be calculated are not just the cumulative negative consequences but the positive ones as well.[19] Proponents of the public health perspective as well as substantial segments of the American population are reluctant to speak of the positive benefits of psychoactive drug use except to the extent they conform with conventional notions of physical health and medical treatment. Alcohol's benefits, for instance, are defined primarily in terms of their potential to reduce heart disease, and those of prescription drugs entirely in terms of their capacity to alleviate pain, depression, anxiety, and feelings that disrupt normal functioning. Yet most people use drugs because they enjoy the effects and many perceive a variety of personal benefits that are rarely measured by physical, medical, or social scientists. Some of these resemble the effects approved by medical and public health criteria, but they typically are not interpreted as such either because they involve an informal form of self-medication or because they confront the common value judgment that one should not have to use psychoactive drugs to be or feel a certain way. The moderate consumption of alcohol as a social lubricant, and of coffee and other caffeinated beverages as a mild stimulant to increase alertness, are probably the most easily accepted and widely acknowledged nonmedical benefits associated with nonprescribed psychoactive drug consumption. But it is also the case that millions of Americans justify

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their past use and/or explain their current use of marijuana, cocaine, hallucinogens, and a variety of other drugs in terms of the benefits that they have derived from their consumption of those substances. Such claims are easily belittled in a society that adopts the notion of "drug-free" as its motto, and are often dismissed by scientists who find such benefits particularly difficult to measure. Nonetheless, it seems inherently unreasonable to dismiss entirely the perceptions of consumers, especially when the negative consequences of their consumption are not apparent. We thus have no choice but to calculate the consequences of changes in drug consumption not just in negative terms but as a net calculation that incorporates both positive and negative consequences.

The second perspective suggested by the supermarket model is that the potential negative health consequences of a free market, or of any other substantial change in policy, are best assessed by considering the respective susceptibilities of different sectors of the population to such changes. I proceed from two assumptions: that it is possible to distinguish among sectors based upon their susceptibility to drug abuse and hence their vulnerability to changes in drug policy; and that close examination of both current and historical patterns of drug use and abuse, as well as other patterns of human behavior, provide important clues into the nature and degree of susceptibility under alternative regimes. Implicit in the second assumption is the recognition that Americans, and most other people, already live in a society in which powerful psychoactive substances are widely available to both adults and children. One need only consider the easy availability of alcohol, tobacco, and caffeine virtually throughout the country; the continued ease of obtaining marijuana and other illicit drugs in much of the country; the extensive presence of powerful psychoactive substances, generally prescribed by medical practitioners, in the medicine closets of American homes; and the entirely uncontrolled availability throughout the United States of many other psychoactive substances, ranging from gasoline and glue to the wide array of drugs available over-the-counter in pharmacies.

What conclusions can be drawn from an analysis of the cumulative consumption of psychoactive drugs in this country? First, virtually all Americans consume psychoactive substances—and even the small minority who appear to abstain entirely, such as the Mormons, seem to compensate by consuming substances that are not traditionally

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viewed as psychoactive, such as sugar and caffeinated soft drinks. Second, a substantial majority of Americans consume these substances only in moderation, suffering little or no harm as a result. Third, the drugs that prove most addictive to most Americans are those, such as cigarettes and caffeinated beverages, that can be easily integrated into everyday life with minimal hassle or disruption. Fourth, virtually all drugs, even heroin, cocaine, and other drugs most associated with destructive patterns of consumption, are consumed in moderation by most of those who use them. [20] Fifth, a substantial majority of those who enter into destructive patterns of drug consumption eventually pass on to either abstinence or moderate patterns of consumption.[21]

When we focus on those who appear most susceptible to destructive patterns of drug consumption, further conclusions are apparent. First, while certain types of drugs are more difficult to use in moderation than others, the principal determinants of destructive drug use patterns involve not the pharmacology of the drug but the set and setting in which the drug is consumed. That is why alcohol consumption among conquered aboriginal groups and cocaine consumption among some inner-city populations have more in common with one another than either does with patterns of alcohol or cocaine consumption among less vulnerable sectors of the population. Indeed, no set and setting is more conducive to extensive and severe drug abuse than the combination of poverty and maladjustment to a mainstream society. Second, those who engage in destructive patterns of consumption with one drug are the most likely to repeat that pattern with other drugs; conversely, those who demonstrate an ability to consume alcohol and common prescription drugs responsibly, or who have succeeded in either stopping or dramatically curtailing their consumption of tobacco, are much less likely to engage in destructive patterns of consumption with other drugs.

Consider the results of recent polls on drug use in the United States. Approximately one-third of Americans over the age of twelve claim that they have not used alcohol in the past year, and close to half report that they have not consumed any alcohol in the past month.[22] In a December 1990 Gallup poll, 43 percent of those polled described themselves as abstainers from alcohol—up from 29 percent in the years 1976–1978.[23] Among African-Americans, the proportion who claim to abstain from alcohol is 58 percent.[24] Of those Americans

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who did drink within the past month, only one in ten (or about 5 percent of the household population) reported that they had drunk heavily during that time.[25] Approximately 75 percent of all Americans over the age of twelve have smoked at least one cigarette; slightly less than 30 percent report that they smoked within the past month, of which half consume about a pack or more a day.[26] With respect to marijuana, about 33 percent of Americans have used it at least once, 11 percent in the past year, 6 percent in the past month, and about 1 percent on something resembling a daily basis.[27] There is reason to believe that there is substantial overlap not only between those who drink heavily and those who smoke heavily, but also between those two groups and those who use illicit drugs heavily—although detailed cross-tabulations of available surveys are required to reach more exact estimates. Indeed, one also finds substantial overlap with those who engage in compulsive gambling and other harmful activities. The principal exception to this substantial overlap may involve the misuse of tranquilizers and other prescription drugs, especially among women. Even if we assume that self-reports of alcohol and tobacco consumption tend to underreport actual consumption by 30–50 percent, we still must conclude that at least 70 percent of Americans are resistant to the sorts of temptations and risks posed by the easy availability of cigarettes, and that more than 90 percent either refrain from powerful drugs altogether or else consume them responsibly and in moderation. This conclusion strongly suggests that a very substantial majority of Americans are immune to any far reaching liberalizations in drug availability for the simple reason that they do not really need drug laws to prevent them from entering into destructive relationships with drugs.

The important question is thus not whether or not millions of Americans would change their patterns of drug consumption under a radically different drug control regime—since there is good reason to assume they would—but rather whether those patterns would be more (or less) destructive than their current patterns of drug consumption. Among the tens of millions of Americans who abstain from alcohol consumption, it seems reasonable to assume that they would have little interest in, and perhaps substantial moral reservations against, consuming other powerful psychoactive drugs. Among the even larger number of Americans who consume alcohol in moderation, despite the great potential for that drug to be consumed

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in a destructive fashion, it is also reasonable to assume that the same individual and societal restraints that protect them against alcohol's seductive powers would control their consumption of other substances. For the vast majority of Americans, therefore, the principal danger posed by a free market in drugs has little to do with drugs like crack cocaine, since so few Americans would be likely either to try it in the first place or, if they did try it, to continue to use it. (Public opinion polls consistently reveal that few Americans believe they would consume cocaine, heroin or even marijuana if those drugs were legally available.)[28]

The greatest danger of a free market in drugs, I suspect, is the possibility that a drug, assumed at first to be relatively safe, becomes popular among millions of Americans and then is revealed to be far more harmful than initially believed. This danger is one that has proven commonplace in the annals of pharmaceutical innovation, medical prescription practice, and inebriation, from morphine and cocaine during the nineteenth century to cigarettes, barbiturates, amphetamine, tranquilizers, and many nonpsychoactive drugs, including steroids, during the twentieth. It is one that has continued to frustrate the regulatory efforts of the Food and Drug Administration in recent decades, and that promises to persist into the future regardless of whether or not the drug laws change substantially. But it is fair to assume that the dangers would be greater if far more products were to become legally available.

The most common fear of legalization, however, is usually of a different sort, and it must be taken seriously. It is that there are millions of Americans for whom the drug prohibition system represents the principal bulwark between an abstemious relationship with drugs and a destructive one. Under a free market regime, it is feared, many of those who currently abstain from, or consume in moderation, alcohol and other powerful intoxicants would become drug abusers, and many of those who already have demonstrated either a potential for, or a pattern of, drug abuse would engage in even more destructive patterns of drug use. Underlying this fear are a variety of assumptions: that the only things which prevent many current users of illicit drugs from engaging in far more destructive patterns of drug use are the high price and lower availability of those drugs under the current prohibition regime; that at least some of the illicit drugs are more seductive than those that are currently legal and/or available;

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that a free market regime would inevitably invite greater levels of drug experimentation, which in turn would lead to higher levels of use and abuse; that many people would be more likely to complement their current drug use with newly available drugs than to substitute those for their current preferences; and that the heightened societal tolerance for more varied psychoactive drug use that would likely accompany a free market regime would lend itself to higher levels of drug misuse.

Even if we assume that the vast majority of those who now consume psychoactive drugs safely would continue to do so under a free market regime, and further assume that a substantial proportion of those who currently misuse illicit drugs would be no worse and quite likely better off under a free market regime, the fact remains that there is a relatively small, but indeterminate, proportion of Americans for whom the drug prohibition system provides not just the image but the reality of security. Figuring out, with some measure of confidence, the magnitude and composition of this vulnerable population is among the most important intellectual challenges confronting those who take seriously the need to estimate the consequences of alternative regimes. And designing policies that minimize the magnitude of this at-risk group without resorting to criminal justice and other coercive measures is surely an even greater challenge.

Most of those who would suffer from the absence of the current drug prohibition regime can be found among those who currently smoke cigarettes and/or abuse alcohol. The first group includes both those adolescents and adults who have demonstrated a willingness or ability to disregard the well known consequences of cigarette smoking, as well as those adults who have demonstrated an inability to abandon a dangerous habit. The second group, which overlaps substantially with the first, includes those adolescents and adults who have demonstrated an inability to control a powerful psychoactive substance, i.e., alcohol, despite the existence of increasingly strong social controls. There are certainly others who neither smoke cigarettes nor abuse alcohol who would enter into destructive relationships with other drugs if they were more readily available, but there is (as I already have suggested) good reason to doubt that their numbers would prove substantial.

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In trying to predict which drugs will prove most popular in the future, who will use them responsibly and who will do so destructively, it is important to keep in mind why people use drugs and why they use the drugs they do. The choice of drugs for most members of most societies can barely be described as a choice at all. Dominant cultures strongly favor some drugs over others, hence the preferred position of alcohol throughout much of the world, with different societies evidencing a preference for beer, wine or distilled liquors, or of coffee in most Islamic societies and quat in some, of kava in some South Pacific islands and coca in the Andes. Alcohol's dominant position no doubt stems as well from the fact that its simple means of production was easily discovered millennia ago by a wide diversity of societies, so that it was not merely readily available in most societies but also provided with substantial opportunity to entrench itself.[29] Tobacco's secondary position somewhat similarly can be attributed to its great success in sweeping the globe and becoming entrenched in a great variety of societies before the emergence of any international capacity for its suppression—although its powerful addictive qualities must also be given credit for ensuring that markets once penetrated remained markets thereafter. As for substances such as kava, betel nut, coca, cannabis, opium, and various hallucinogens, each has benefited, not unlike alcohol, from being an indigenous product.

To the extent that drug consumption patterns and preferences can really be described as a choice, it is fair to say that people choose those drugs that give them what they want. Most people can in fact be described as rational consumers even in their choice of psychoactive drugs. They use drugs because they seek or like their effects, whether those involve relief from pain, reduction of stress and anxiety, release from inhibitions, stimulation of the senses and the intellect, enhancement of physical or mental performance, or any of the many other psychoactive effects of drugs. Most people, moreover, tend to limit their consumption in order to minimize the negative consequences, whether those involve hangovers, heart disease or cancer. The evidence from a broad variety of cultures suggests that the single most important determinant of a drug's popularity is its capacity to be integrated into ordinary lives with minimal disruption.

It is important to recognize that the same notion of rational drug consumption applies to some extent even to those who are engaged

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in highly destructive patterns of consumption. For many hard core drug users in the inner cities and among aboriginal populations, their intensive involvement with powerful drugs provides a powerful source of relief from emotional and other psychological pain, some excuse for isolating themselves both from mainstream society and difficult personal responsibilities, and (particularly for those most engaged in the day to day hustling for the means to procure their expensive drugs) a source of self esteem and motivation to keep getting out of bed in the mornings despite the absence of any promising prospects in their lives. This is not to say, of course, that the destructive drug use patterns of those living on the edge of despair can be described as entirely rational. But it is to say that even hard core drug abusers tend to prefer drug consumption options that minimize the risks of death in both the long and the short-term; the growing evidence about the willingness of intravenous drug addicts to take modest steps to reduce the likelihood of contracting the HIV virus attests to this.[30] Relatively few hard core drug addicts can be described as truly committed to an early death. It is thus reasonable to assume that even most current and potential hard core drug users will, if given the choice, opt for drugs that are, at the very least, no more dangerous than those consumed today.

One can supplement the notion of rational drug consumption, which focuses on the individuals' preferences, with another notion also drawn from libertarian philosophy. It is that societies, like individuals, generate nonlegal social norms in the absence of governmental prohibitions and other restrictive laws. Societies, simply stated, are not entirely at the mercy of free markets, but retain the potential to create self-protective mechanisms designed to minimize the risks presented by such markets. Indeed, some libertarians argue, one of the more significant costs imposed by governmental prohibitions is the withering of societal norms that often operate more powerfully and effectively than governmental interventions. Evidence in support of this argument can be found in anthropological and sociological studies of traditional and modern cultures alike, wherever patterns of human intercourse are allowed to evolve in the absence of significant governmental prohibitions. Particularly reassuring in this regard are the many decriminalizations that one can point to throughout civilized human history that were opposed by those who feared for the civility and even the survival of society but

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that turned out to be far less destabilizing than was feared. Such fears impeded efforts to do away with restrictions on speech, press, religion and assembly, on relations between people of different classes and races, on sexual and familial relations, and on the availability of psychoactive drugs that are now integrated into modern society.[31] The same sorts of unjustified fears now stand in the way of efforts to do away with current drug prohibitions.

The arguments of the libertarians are both powerful and, at least with respect to the majority of society, quite convincing. They confront, however, three counterarguments that most Americans currently find compelling. The first is simply that drugs and drug consumption are fundamentally different than all other commodities and activities—so different that ordinary libertarian assumptions do not apply. The second, like the notion of rational drug consumption, derives from economic reasoning. It is the evidence that suggests that levels of consumption of desirable consumer items tend to increase as their availability increases and their price decreases. And the third is the epidemiological evidence suggesting that the negative consequences associated with the use of any drug in a society are a direct function of the overall level of use of that drug. Of these three arguments, the first represents the weakest in terms of logical analysis but the most powerful from an emotional and political viewpoint. It can be repudiated by reference to the many ways in which other commodities and activities generate the same sorts of behavior as do the consumption of drugs, be it the alteration of consciousness, the transformation of social behavior or the creation of dependent relationships.[32] But the belief in the unique power of psychoactive drugs is so entrenched in our society that even highly prominent liberal theorists, including those with strong libertarian inclinations, either avoid the subject altogether or else carve out awkward exceptions to their otherwise more coherent philosophies. The second and third arguments, by contrast, present far more powerful reasons to refrain from placing one's faith entirely in libertarian assumptions.

There are other reasons as well to put the purist libertarian assumptions and the supermarket model to the side. The more one speculates about the consequences of such a model, the more one realizes that all sorts of additional assumptions have to be made about the type of society that would favor such a model—and that

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these assumptions are even more speculative than anything we assume about the vulnerability of today's population to such a model. At the very least, the sets and settings that so powerfully shape the nature and consequences of drug use would inevitably differ dramatically from their contemporary formulations. Furthermore, as soon as one engages in the process of trying to think through the consequences of such a model, one encounters the inevitable tendency to begin framing restrictions on the supermarket. Whether one analogizes to alcohol and tobacco, or to the nineteenth-century model of widespread drug availability, one confronts the tendency both in the United States and elsewhere to impose restrictions on the distribution of psychoactive drugs.

## THE "RIGHT OF ACCESS" MODEL

We thus return to the question: How can the risks and harms of the free market model be reduced without undermining the many benefits that such a model offers? And how far can the free market model be stretched without giving up its essential feature? That essential feature, it must be stressed, is the legal availability of drugs in the absence of any requirement that the permission of a government-sanctioned gatekeeper be obtained beforehand. It is that feature that distinguishes the legal status of alcohol, tobacco, caffeine, and aspirin from that of marijuana, cocaine, morphine, and Valium—and that accounts for the generally greater and easier availability of the legal drugs compared to the illegal drugs. Legal drugs are almost always available over-the-counter; illegal drugs are not. Government-sanctioned medical authorities and pharmacists, and sometimes additional barriers as well, stand between the illegal drug and the person who wishes to obtain it.

It is important to recognize that legal availability does not always connote easy availability, and that the restricted legal status of a drug does not always make it that difficult to obtain. Legal drugs may, for instance, be so expensive—either because of high costs of production or high taxes—that they are for all intents and purposes unavailable to many potential consumers. Distribution channels may be relatively undeveloped or otherwise circumscribed. And efforts by government to restrict severely the availability of a legal drug without depriving consumers entirely of the right to purchase it legally may prove

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successful. Powerful evidence in support of these propositions can be found in the alcohol control efforts of the United States, Australia, and much of Europe during the 1920s and 1930s. Whereas the former initially favored Prohibition, the latter opted instead for tough, but nonprohibitionist, regulatory regimes. The results were more substantial, and more lasting, declines in alcohol consumption and alcohol-related ills in Europe and Australia than in the United States.[33]

Illegal drugs, by contrast, can occasionally prove to be highly available. Medical practitioners often write prescriptions for mild tranquilizers, sedatives, and other psychoactive drugs in response to their clients' plaints. They may do so because they believe that such drugs are a proper and effective way of medicating their clients, or because they believe that a client's satisfaction with a visit to her doctor depends in part upon the doctor's willingness to end the visit by writing a prescription. And even apart from such channels, illegal drugs can prove readily available wherever substantial markets generate high levels of supply—as was the case with marijuana in much of the country during the 1970s and 1980s. The same holds true of more localized markets, in particular the inner-city markets for cocaine since the mid-1980s as well as for other drugs that have attained high levels of popularity in particular neighborhoods or cities. In cases such as these, illegal drugs may prove more available than many legal drugs, such as alcohol, for which the hours of sale are often restricted by government. In many highly restricted environments, moreover, such as prisons, jails, and mental institutions, illegal drugs are often more available than alcohol because their smaller bulk makes them easier to smuggle past guards and other barriers.

The foregoing analysis suggests that it is possible to construct legal drug control regimes in which certain drugs may be less available than is the case under prohibition regimes. When we stretch as far as possible from the free market extreme of the drug policy continuum, but seek at the same time to retain the basic feature of nongatekeeper accessibility, the model that emerges is one that might be called the "right of access" or "mail-order" model. It is based on the notion that adults should be entitled not merely to the right to possess small amounts of any drug for personal consumption but also to the right to obtain any drug from a reliable, legally regulated source respon-

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sible (and liable) for the quality of its products. In identifying such a right, I must stress, I do not mean to suggest that it is on a par with the more privacy-based right of possession and/or consumption, but merely that it provides a useful parameter—both ethically and conceptually—for designing alternative drug control policies. Unlike the supermarket model, the right of access model is one that can be superimposed on the current drug prohibition system.

If such a right of access were legally acknowledged by Congress or the Supreme Court—a prospect, I recognize, with scant political or jurisprudential potential in the foreseeable future—those desirous of minimizing the potential threat to public health might well advocate the notion of a mail order system. In order to ensure a right of access to all residents of the United States no matter where they might live, at least one mail order source would have to be available in the United States from which any adult could order a modest amount of any drug at a reasonable price reflecting production costs and taxes. Most states, cities, and other communities might well continue to prohibit the sale and public consumption of most drugs within their jurisdictions as they do now, but would be obliged to acknowledge the basic right of access by mail order as well as the basic right of possession and consumption. Some localities might also adopt, if they had not already done so, the various sorts of harm reduction policies that are advisable under any regime. One might also imagine many other local variations by different states and municipalities to accommodate the particular health, criminal justice, and moral concerns of each. But the option of ordering one's drugs by mail would allow any adult to opt out, in effect, of the local control system insofar as private consumption was concerned.

The right of access notion offers us, I think, a more valuable, modest, and realistic alternative extreme than the supermarket model from which to stretch toward the optimal policy. As a model, it retains in skeletal form the essence of a legalization regime, which is the elimination of any sort of gatekeeper—policeman, doctor, pharmacist, etc.—between the seller and consumer of drugs with the power to deny the latter access. It thus strikes at the heart of much of what is wrong with drug prohibition, in particular the creation of violent and powerful black market entrepreneurs, the harms that result from unregulated production of psychoactive drugs, and the many infringements on individual freedoms. But it also provides a

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skeletal framework that can be filled out with many of the sorts of antidrug abuse measures that we associate with both harm reduction approaches to illicit drug control policy and public health approaches to alcohol and tobacco control. It has the advantage of resembling actual models in other domains of public policy both today and in recent history, including the alcohol distribution system in Canada and Sweden during the early decades of this century as well in pre- and post-Prohibition United States, and the modification of FDA policy in recent years to allow individuals to import by mail small amounts of drugs that are legally available outside the United States but that have yet to be approved by the FDA for the treatment of AIDS or cancer.[34] Given the preference among critics of drug prohibition for a fairly high degree of "local option," it addresses the inevitable tensions among different state and local drug control policies, between those policies and federal policies, and even (albeit to a lesser extent) between domestic policies and international requirements. At the same time, it offers a paradigm for addressing and reconciling the tensions between individual rights and communitarian interests that lie at the heart of so many struggles over public policy in democratic societies.

This model is not, I must stress, a panacea, nor should it be misconstrued as a final proposal for an alternative drug control regime. It raises numerous questions such as how such a mail-order system would be established and maintained, who would run it and *profit from it, who would oversee it,* who would have access to its mailing lists and other information about consumers, how consumer privacy would be protected, how minors would be prevented from taking advantage of it, how new drugs would be made available, and so on. Most of these questions strike me as susceptible to fairly precise answers, in good part because there are so many close analogies to a mail-order system. More difficult to assess are the same sorts of questions raised by the supermarket model and all other alternative models, in particular those that focus on assessing changes in psychoactive drug consumption—although I assume that they are easier to answer with respect to a mail-order model since such a system is more readily integrated with the current prohibition model than is the case with the supermarket model.

One prominent difference between the right of access or mail-order model and the supermarket model is that the former fails to eliminate

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the black market. Just as some gun control laws rely on waiting periods between the time a person orders a firearm and the time he obtains possession, so a mail-order system imposes a sort of waiting period—presumably a minimum of one day. It is highly reasonable to assume that black markets would persist not only to supply minors—which is presently the case with most psychoactive substances, including alcohol and tobacco—but also to supply those who will not or cannot wait to obtain their drugs from the mail-order system, as well as those who want to obtain more at any one time than is allowed by law.

We typically assume that an important objective of legalizing drugs is to undercut the black markets and place them in the hands of either government or government-licensed and regulated distributors. This objective is tempered by the recognition that there are better and worse features of illicit markets, and that a preferable drug policy ideally would focus on eliminating the worst while tolerating the better features. It would, for instance, attempt to undermine the accumulation of power by organized criminals, reduce the violence that attends such markets and generally push large-scale production into the hands of regulated, tax paying, and collecting producers and distributors. But at the same time, it might well choose to ignore smaller scale illicit markets—what are often referred to less disparagingly as informal or unregulated markets—which are of value not just because they often prove more innovative and enterprising in designing and offering new products but also because they provide an important source of income for many people who face substantial disadvantages in their efforts to penetrate and succeed in the more established legitimate markets. This holds true, for instance, of both rural producers of marijuana and inner-city entrepreneurs engaged in the low-level distribution of crack and other drugs. Two probable advantages of the right of access model are that it would effectively undercut efforts by organized criminals to create highly profitable national distribution systems, since any adult could purchase the drugs by mail. At the same time, it would not eliminate many illicit small scale, localized production and distribution systems that meet local demands for immediate availability, rapid delivery, and specialized products. Local authorities could choose, in effect, either to suppress such black markets vigorously or to manage them through conventional vice control methods. But the scale of such markets

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would probably bear a closer resemblance to illicit prostitution rings in cities that sanction regulated prostitution than to contemporary illicit drug markets.

## TRANSITION ISSUES

Few drug control regimes are static. Prohibitions, regulations, and decriminalizations tend to evolve as new drugs emerge, as drug use patterns shift, as other drug-related norms change, and as popular and elite perceptions of various drugs, drug consumers and drug problems shift. In contemplating alternatives to the current drug prohibition regime, we need to distinguish between transition phases, longer term consequences and equilibria, keeping in mind that there is no drug control regime that will suffice forever. The distinction is important with respect to issues of both drug consumption and black markets. It is safe to assume that illicit markets do not just shrivel up and die when confronted with competition from licit markets. Rather, illicit entrepreneurs may continue to compete with licit markets during the initial phase when licit producers and distributors are still gearing up, having the advantage of their previous investments in production and/or distribution as well as their expertise. The share of the market that is captured by legal producers and distributors in the long-term, however, probably would depend more on price, availability, competition, the intensity of continued law enforcement efforts to suppress the remaining black market, and changing tastes and fads among consumers. There are also important policy questions regarding the extent to which those involved in the illicit markets during prohibition should be allowed or encouraged to play a role in legal markets after prohibition.

Close examination of the aftermath of Prohibition in the United States, other postprohibition periods elsewhere, and other decriminalizations, such as of gambling, prostitution, pornography as well as of nonvice markets in countries experiencing significant deregulations (such as the former Soviet bloc countries) can provide important insights into how drug markets are likely to evolve.[35] The impact of decriminalization on those involved in illicit drug dealing, as well as on those who would have become involved in drug dealing but for decriminalization, is especially important when we focus on African-American and Latino youth in the urban ghettos. Clearly the

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dramatic drop in the price of currently illicit drugs following decriminalization would greatly reduce one of the most powerful incentives for engaging in drug dealing and other criminal activities. According to a recent report by the Justice Department's Bureau of Justice Statistics, 13 percent of all convicted jail inmates, and 19 percent of those convicted of drug trafficking offenses, said they had committed their offense to obtain money to buy illicit drugs.[36] Dramatic reductions in the size and profitability of the illicit markets would also remove the powerful financial and social incentives that have lured so many urban youth into drug dealing activities even before they began to consume illicit drugs.

Further insights into this question can be derived both from analyzing the response of bootleggers to the repeal of Prohibition and from observing how illicit drug dealers adapt when illicit drug markets decline, as seems to be the case today.[37] Illicit vice entrepreneurs seem to respond to decriminalizations and shrinkages in illicit markets in any of four ways. Some succeed in making the transition to legal entrepreneurship in the same line of work. Some seek to remain in the business illegally, whether by supplying products and services in competition with the legal market or by employing criminal means to take advantage of the legal markets. For instance, following Prohibition, some bootleggers continued to market their products by forging liquor tax stamps, by strongarming bartenders into continuing to carry their moonshine and illegally imported liquors, and by muscling their way into the distribution of legal alcohol. Some also fought to retain their markets among those who had developed a taste for corn whiskey before and during Prohibition. The third response of bootleggers and drug dealers is to abandon their pursuits and branch out instead into other criminal activities involving both vice opportunities and other sorts of crime. Indeed, one potential negative consequence of decriminalization is that many committed criminals would adapt to the loss of drug dealing revenues by switching their energies to crimes of theft, thereby negating to some extent the reductions in such crimes that would result from drug addicts no longer needing to raise substantial amounts of money to pay the inflated prices of illicit drugs. The fourth response—one that has been and would be attractive to many past, current, and potential drug dealers—is to forego criminal activities altogether. Relatively few criminal pursuits can compare in

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terms of paying so well, requiring so few skills, remaining fairly accessible to newcomers, and presenting attractive capitalist opportunities to poorly educated and integrated inner-city youth. During Prohibition, tens if not hundreds of thousands of Americans with no particular interest in leading lives of crime were drawn into the business of illegally producing and distributing alcohol; following its repeal, many if not most of them abandoned their criminal pursuits altogether. There is every reason to believe that drug decriminalization would have the same impact on many involved in the drug dealing business who would not have been tempted into criminal pursuits but for the peculiar attractions of that business. The challenge for researchers, of course, is to estimate the relative proportions of current and potential drug dealers who would respond in any of these four ways. The even broader challenge is to determine the sorts of public policies that would maximize the proportion that forego criminal activities altogether.

The need to distinguish between transition phases and longer term consequences and equilibria also applies to the impact of decriminalization on potential and current illicit drug users. The initial liberalization of availability is likely to spark high levels of curiosity, stimulated both by the media and by the mere fact of legal access, and substantial experimentation with different drugs—but it is reasonable to assume that this would moderate over the long-term. At the same time, the initial reluctance of many Americans to try newly available drugs to which they are unaccustomed may fade over time. Those who have grown up under a prohibition system, moreover, and have thus been influenced to one degree or another by the many assumptions that prohibition conveys about drug use, are likely to experience a legal regime differently than succeeding generations for whom it will represent the norm.

## GATEKEEPERS, NORMS, AND INFORMATION SYSTEMS

There is also the question of how a liberalization of legal availability will affect both the doctor-patient relationship and the role of pharmacists. It would be useful to know, for example, what proportion of visits to doctors are motivated principally by the desire or need to obtain a prescription for a controlled substance. Between one-half and two-thirds of all consultations with doctors result in the

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writing of a prescription.[38] A legal drug regime would negate the need for visits motivated solely by the need to obtain a prescription, with mixed results. Some people would suffer as a result of not being obliged to consult with a doctor, but many others who now must waste time and money on unnecessary doctor visits would surely benefit. The problem of undermedication, and particularly undertreatment of pain, would almost surely be less of a problem than it is now. But some people would surely be more likely to use inappropriate drugs and to develop unhealthy dependencies on drugs that are now available only by nonrenewable prescription. Better insights into these issues can be gained by analyzing the available evidence about why people go to doctors as well as patterns of self-medication and doctor visitation in other times and places in which there have been fewer controls on the availability of drugs.[39]

The role of doctors and pharmacists as gatekeepers for prescription drugs is of course part and parcel of a broader question about the basic need for creating and maintaining a distinction between over-the-counter and prescription drugs. This question has been addressed most sharply by economists, although the literature on the broader implications of the distinction remains quite limited.[40] The notion of requiring prescriptions for drugs other than cocaine and opiates is, as Peter Temin wrote in his historical study of drug regulation in the United States, a relatively recent notion—one that was not consonant with the 1938 Federal Food, Drug, and Cosmetic Act but that emerged in spite of a legislative intent to the contrary.[41] Implicit in the notion was the belief that many Americans would not act rationally in their choice and use of drugs and thus needed to be shielded from their own irresponsibility by governmental controls. One result was a significant constriction in the provision of information about drugs to consumers. The supposition that a mandatory drug prescription system plays an essential role in protecting the health of consumers has yet to be systematically tested. One study that employed a cross-national comparative perspective concluded that the prescription requirement did not yield a net benefit in health effects.[42] Another, by Peter Temin, suggested certain criteria that could be used to determine when a drug should be restricted or made available over-the-counter.[43] These studies provide valuable insights, but they represent only a small step in the direction of determining

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the likely consequences of severely restricting or eliminating the mandatory prescription system.

I should stress that these issues are at least as important with respect to the urban ghettos as they are in thinking about middle class drug usage. Much illicit drug abuse in urban ghettos can fairly be described as a form of self-medication for depression and other psychological pain among people who tend not to seek out psychiatrists and other doctors for such ills. The drugs they use to hide and forget their pains—alcohol, illegal heroin and cocaine, and other "street" drugs—are often more dangerous but no more effective than those prescribed to middle class patients by their doctors. At the same time, urban ghettos are full of poor people who might well benefit from access to the same sorts of antidepressants and other drugs that middle class Americans obtain from their doctors but who fail to obtain them both because they eschew the illicit markets and because financial and cultural limitations preclude visits to doctors. Here it is worth pointing out the patent absurdity of the claim that drug legalization would devastate inner-city populations. Both legal and illegal drugs are already so widely available in inner cities that virtually any resident can obtain them far more quickly than in suburban neighborhoods. But a liberalization of drug availability would make more easily available drugs that are safer than those now sold in urban liquor stores, crack houses, and street markets. At the same time, it would substantially reduce the negative consequences of prohibition—all of which are felt most severely in the urban ghettos.

More broadly, there is good reason to think that a regime of legal availability would substantially, even radically, transform the ways in which Americans relate to psychoactive drugs. One might well imagine that pharmacological experts, certified perhaps by either government or professional agencies, would play an increasingly important role not so much as gatekeepers but as educators and consultants on the preferred uses of drugs for medicinal, psychotherapeutic, recreational, and other purposes. But even more importantly, nonlegal norms would undoubtedly emerge in the absence of current prohibitionist norms to shape the way people relate to drugs, the ways in which they use them, and the cautions they exercise. Here again, there is the question of determining which people are likely to prefer the least potent and least risky drugs and which are more likely to opt for the most potent, quickest acting, and so on. There is also

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the possibility that a world of widespread drug availability might be more likely to generate self-protective norms against all forms of drug taking. And it is fair to assume that far more people would assume greater responsibility for their relationship to drugs than is currently the case, since the gatekeeper role of doctors effectively transforms consumers into far more passive actors.

This in turn leads to the question of how information about psychoactive drugs could be better distributed to a population so that it is readily available and intelligible to typical consumers. The challenges here are fourfold. The first is to design an effective means of distinguishing among categories of drugs so that those who purchase either by mail or at retail outlets are properly informed of the risks and appropriate uses. This task could be performed by either a Food and Drug Administration (FDA) or a nongovernmental agency such as Consumer Reports, or both. The second is to design an information system separate from the distribution systems whereby consumers can obtain necessary information on their own at little or no cost. This might involve information distribution systems accessible by telephone or other easily accessed computer hookups. Current efforts by the FDA, and by consumer organizations such as those promoted by Ralph Nader, to ensure that consumers are provided with both more accurate and more accessible information may well provide something of a model in thinking about issues such as these. The third challenge is to create honest drug education programs that tell children the truth about drugs without stimulating premature desires to try them.[44] And the fourth is to design public health campaigns that effectively discourage drug misuse without resorting to lies, scare tactics, and the demonization of people who use drugs. The public service advertisements directed at discouraging tobacco consumption and drunken driving provide far better models in this respect than the "Fried Egg" ads, caricatures, and untruths promoted by the Partnership for a Drug-Free America.[45]

Most of what people know about drugs they have never used comes from the commercial media. It has repeatedly played a central role in transforming local fads and fashions into national and even international phenomena.[46] We can safely assume that it will play a crucial role in the distribution of information and the shaping of public perceptions about drugs, particularly those that are relatively unfamiliar to most Americans. One need only imagine what impact

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the news magazines' cover stories in late 1989 and early 1990 on the new antidepressant, Prozac, would have had if Prozac were available over-the-counter or by mail; indeed, it would be interesting to know what impact those stories actually did have on potential consumers.[47] How many people, for instance, visited doctors thereafter with the intention of obtaining prescriptions for Prozac, how many succeeded, and—even more difficult to say—how many benefited or suffered as a consequence? Conversely, how many people who might benefit from Prozac have not yet tried it solely because they are unaccustomed to visiting a doctor to obtain assistance in alleviating depression? Certainly there is good reason to fear the media's impact on drug consumption preferences under a legal regime given its historic and persistent incapacity to provide accurate and balanced information about psychoactive drugs.[48] On the other hand, the media occasionally has demonstrated its capacity to shape preferences in healthier and otherwise better directions. It is certainly a loose cannon insofar as our efforts to evaluate the future direction of drug use are concerned. But there is good reason to devote at least some effort to considering how the media has shaped drug consumption patterns in the past.

The issue of advertising is a difficult one. In 1986, the Supreme Court ruled in *Posadas de Puerto Rico Associates vs. Tourism Company of Puerto Rico* that strict restrictions on advertising casino gambling were constitutionally permissible.[49] There seems to be little question that comparable restrictions on advertising psychoactive drugs would also be regarded as legal.[50] The difficult issues thus involve balancing the costs and benefits of both specific types of advertising as well as the advertising of psychoactive products generally. There is good reason to fear, and to curtail, the mass promotion of psychoactive drugs that present the sorts of harm associated with alcohol and cigarettes.[51] There are also substantial incentives to avoid a revival of medical quackery and the mass marketing of patent medicines that once tricked millions of Americans into buying products that did them little good and occasionally much harm. On the other hand, advertising can play a valuable role in informing people of new and beneficial products, in luring consumers to switch from more dangerous to less dangerous drugs, and in promoting competition that saves consumers money.[52] This is true of both psychoactive and nonpsychoactive drugs as well as those

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used for both recreational and more traditional therapeutic purposes. The solution to the advertising dilemma—to the extent we are willing to put aside First Amendment concerns—may well lie in a combination of restrictions on the promotion of more harmful products with vigorous educational campaigns to discourage their consumption.

## CONCLUSION

Predicting human behavior remains, and shall always remain, an imprecise art. Social science can provide modest insights into the consequences of incremental changes in regulatory structures on human behavior. But when we try to envision the consequences of more far reaching changes in such structures, our confidence in social science insights falters. The variables are too numerous, the changes in individual and societal consciousness too unpredictable, and the tools too paltry to pretend that we can really know the future. Here history offers a more powerful guide—with its potential to shed light on both the accretion of incremental changes and the suddenness of revolutionary change. But even its lessons are limited by unanswerable questions regarding the potential of the future to evolve in unprecedented ways. Ultimately our predictions are bounded by theories of human behavior, and particularly of human and societal vulnerability and resilience, that have more to do with our visceral fears and confidences than any objective readings of the evidence.

When we switch from predicting the future to trying to plan it, our preferences are determined not only by our calculations of their consequences but also by our choices among competing ethical values. Such choices may be made implicitly, as when we accept without question conventional ethical values, or explicitly. They establish the parameters beyond which policy options will not be considered. They influence our calculations of the costs and benefits of various options. And they guide us in deciding who should benefit and who may be harmed by choosing one option over another. There are no objective standards by which to choose among ethical values. One can only appeal to conscience, principle, and empathy.

The challenges of evaluating radical alternatives to our current drug prohibition system are formidable. But so are the challenges of predicting the consequences of persisting with our current policies. In 1960, few Americans had ever heard of LSD, and the notion that

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sixty million Americans would smoke marijuana during the next three decades would have seemed bizarre to most Americans. In 1970, few Americans gave much thought to cocaine, and most would not have believed that twenty-five million Americans would try it during the next two decades. By the late 1970s, many Americans believed that marijuana would be sold legally within a few years. In 1980, no one had ever heard of "crack" cocaine; the notion of an AIDS epidemic among injecting drug users seemed inconceivable; and the prospect of a quarter-million Americans in jail or prison by 1990 for violating drug prohibition laws seemed preposterous. Clearly, retention of our drug prohibition system provides no guarantees about future patterns of drug use or the scale of future drug problems. Legalization may present a wider array of possibilities, but its uncertainties are not dramatically greater than those of persisting with prohibition.

There are powerful reasons for taking seriously the alternatives to drug prohibition. The first is simply that drug prohibition has proven relatively ineffective, increasingly costly, and highly counterproductive in all sorts of ways that many Americans are only beginning to appreciate. Nowhere is this more true than in the urban ghettos, where the war on drugs has failed to reduce the availability of illicit drugs or the incidence of drug abuse and offers no prospect of doing so in the future. At the same time, these neighborhoods and their residents have suffered the negative consequences of drug prohibition more severely than any others. Not unlike Chicago under Al Capone, they must live with the violence and corruption generated by prohibition, the diversion of law enforcement resources, the distortion of economic and social incentives for their youth, the overdoses that result from unregulated drugs, the AIDS that spreads more rapidly because clean syringes are not legally or readily available, and the incarceration of unprecedented numbers of young men and women. Those who contend that legalization would mean writing off impoverished inner-city neighborhoods ignore the remarkable extent to which drug prohibition has both failed and devastated the urban ghettos. Drug legalization offers no panacea, particularly if it is not accompanied by more fundamental changes in the norms and leadership of urban societies. But there is no question that it can alleviate many urban ills at relatively little risk.

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Second, there are good reasons to believe that a nonprohibitionist regime would not result in dramatic increases in drug abuse. Public opinion polls reveal that few Americans believe they would use drugs that are now illicit if they were legally available. Important implications, moreover, can be derived from the observation that we already live in a society in which all sorts of psychoactive substances are cheaply and readily available to both adults and children. Legalizaton would make more drugs more available than they are today, but it would not present a situation dramatically different from that which currently exists. The same sorts of norms and interests that prevent most Americans from misusing drugs today would persist. And even many of those who do misuse illicit drugs would be no worse off, and in many ways better off, under an alternative regime. Some Americans would suffer from the abolition of drug prohibition, but all the evidence suggests that their numbers would be modest. We possess, in short, substantial evidence of a fundamental societal resilience in the face of widespread drug availability.

Third, there are also good reasons to anticipate positive shifts in drug consumption patterns if we move in the direction of nonprohibitionist controls. The current drug control regime favors certain legal and illegal drugs over others that may well present fewer dangers to both consumers and society generally. Under a legalization regime, alcohol and tobacco would no longer be artificially favored by their legal status. Crack cocaine would no longer benefit from the perverse dynamics of the illicit market. And traffickers and consumers would no longer be obliged to favor more compact and potent drugs over bulkier but more benign substances simply because the former were less detectable. Both illicit drug abusers and responsible consumers, particularly among the poor, would have better access to drugs that are safer than those that are most available now. Drug legalization might thus result in more consumption of a wider array of substances than is currently the case but with dramatically fewer negative consequences.

Fourth, those who take seriously such values as tolerance, privacy, individual freedom, and individual responsibility have little choice but to seek out alternatives to the current system. These values are fundamentally at odds with a prohibition regime that criminalizes the possession of small amounts of any drug for personal consumption. They are seriously threatened, moreover, by a war on drugs that

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promotes notions of zero tolerance toward drug users, that pursues its objective of a drug-free society with few restraints, that encourages neighbors and family members to inform on one another, and that incarcerates hundreds of thousands of Americans for engaging in vice activities that were entirely legal less than a century ago.

In proposing a mail-order distribution system based on a right of access, I have tried to offer a model that strikes at the heart of what is most problematic about drug prohibition. I realize that such a model is easily mocked by those with little interest in thinking seriously about alternatives to drug prohibition. My intended audience are the progressive prohibitionists and legalizers of all stripes interested in developing the discourse about alternatives to drug prohibition. I believe the model offers an effective means of eliminating or reducing the worst consequences of drug prohibition. It represents the best compromise I can envision between individual rights and communitarian interests. It provides for both a skeletal framework at the federal level and substantial flexibility for local option at the state and local level. It allows for substantial latitude in implementing public health measures and campaigns designed to reduce drug abuse. And it offers a system that can be fairly easily superimposed on the current prohibition system.

The model does not, to be sure, represent a panacea. It raises as many questions as it answers. Like any other model, it has its vulnerabilities and it is susceptible to abuse by those determined to take advantage of it. Its potential effectiveness depends, moreover, on the extent to which it is filled out with sensible and humane drug control policies at state and local levels of government. But it does compare favorably, I believe, with both the American prohibition system and the supermarket model preferred by extreme libertarians. It presents greater risks than the conventional, prohibition-bound harm reduction model one finds in parts of Europe and Australia, but it also offers far more potential to transform drug consumption patterns in both the urban ghettos and the population at large in safer directions.

Intellectual ruminations about supermarket models, mail-order distribution systems, and a right of access to psychoactive drugs seem far removed from current political debates over drug control policy in the United States. There are, nonetheless, good reasons to develop the intellectual capital associated with the analysis of alternative drug

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control regimes. First, scholars are obliged to pursue their intellectual inquiries unencumbered by the blinders imposed by current prejudices and political realities. To limit the questions that one asks and the answers that one ventures to those sanctioned by officialdom is to forsake our moral and intellectual obligations to both our profession and our society. Future generations are ill served if today's scholars uniformly submit to the intellectual conservatism that so dominates social science and public policy analysis. Second, many of the assumptions that underlie both the current war on drugs and the prohibition system itself have not been systematically examined for a long time. Even those who desire no substantial revisions in drug control policies can benefit from such an appraisal. Third, no one knows what the future will bring. New drugs and new ways of altering one's state of consciousness will surely emerge. The challenges of regulating psychoactive drugs are certain to increase. And the pharmacological Calvinism that dominates contemporary American public opinion and policy analysis can only persist for so long.

Cost-benefit analysis can, and should, play an important role in the debate over the future of drug control policy, if only because it provides us with the closest thing to an objective framework of analysis for clarifying our objectives and assessing our options. Ultimately, however, the debate over drug policy is really a debate over competing moral visions of society. I see no merit, and much evil, in calls for zero tolerance and a drug-free society. I also see nothing immoral, I must admit, about the consumption of psychoactive drugs by those who do no harm to others and who fulfill the obligations they have assumed to others. The challenge, from my perspective, is one of designing and promoting a drug control policy that combines a healthy respect for individual freedom and responsibility with a strong sense of compassion. These values do not trump all others all of the time. But it is important that they be not forgotten or pushed to the side whenever the fearful specter of DRUGS is uttered.

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ENDNOTES

[1]The relationship between the current debate over drug legalization and prior debates is analyzed in Ronald Bayer, "Introduction: The Great Policy Debate—What Means This Thing Called Decriminalization?," *Milbank Quarterly* 69 (3) (1991): 341–63.

[2]See the following articles by Ethan A. Nadelmann, "Drug Prohibition in the United States: Costs, Consequences and Alternatives," *Science* 245 (1 September 1989): 939–47; "U. S. Drug Policy: A Bad Export," *Foreign Policy* 70 (Spring 1988): 1–39; and "The Case for Legalization," *The Public Interest* 92 (Summer 1988): 3–31. Also see James Ostrowski, "The Moral and Practical Case for Drug Legalization," *Hofstra Law Review* 18 (3) (Spring 1990): 607–702; Richard Lawrence Miller, *The Case for Legalizing Drugs* (New York: Praeger, 1991); Arnold S. Trebach, *The Great Drug War* (New York: Macmillan, 1987); Steven Wisotsky, *Breaking the Impasse in the War on Drugs* (Westport, Conn.: Greenwood Press, 1986); and the collections of articles in Melvyn B. Krauss and Edward P. Lazear, eds., *Searching for Alternatives: Drug-Control Policy in the United States* (Stanford, Calif.: Hoover Institution Press, 1991); in David Boaz, ed., *The Crisis in Drug Prohibition* (Washington, D.C.: CATO Institute, 1990); in Ronald Hamowy, ed., *Dealing with Drugs: Consequences of Government Control* (Lexington, Mass.: Lexington Books, 1987); in Arnold S. Trebach and Kevin B. Zeese, eds., the three-volume *Drug Prohibition and the Conscience of Nations* (Washington, D.C.: Drug Policy Foundation, 1990), *The Great Issues of Drug Policy* (1990), and *New Frontiers in Drug Policy* (1991); and in Bruce K. Alexander, *Peaceful Measures: Canada's Way Out of the 'War on Drugs'* (University of Toronto Press, 1990).

[3]Recent efforts to analyze nonprohibitionist drug policy options include Doug Bandow, "Dealing with Legalization," *The American Prospect* 8 (Winter 1992): 82–91; and Chester Nelson Mitchell, *The Drug Solution* (Ottawa: Carleton University Press, 1990). A proposed research agenda can be found in Ethan Nadelmann, "Beyond Drug Prohibition: Evaluating the Alternatives," in Krauss and Lazear, eds., 241–50.

[4]See Franklin E. Zimring and Gordon Hawkins, *The Search for Rational Drug Control* (New York: Cambridge University Press, 1992), 82–110; and Mark A. R. Kleiman and Aaron J. Saiger, "Drug Legalization: The Importance of Asking the Right Question," *Hofstra Law Review* 18 (3) (Spring 1990): 527–66.

[5]See, generally, Pat O'Hare, Russell Newcombe, Alan Matthews, Ernst C. Buning, and Ernest Drucker, eds., *The Reduction of Drug Related Harm* (London: Routledge, 1991); Peter McDermott and Pat O'Hare, eds., *Reducing Drug-*

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*Related Harm: New Developments in Theory and Practice* (London: Whurr Publishers, 1992); and Nick Heather, Alex Wodak, Ethan Nadelmann, and Pat O'Hare, eds., *Psychoactive Drugs and Harm Reduction: From Faith to Science* (London: Whurr Publishers, 1993). Also see John Strang and Gerry V. Stimson, eds., *AIDS and Drug Misuse: The Challenge for Policy and Practice in the 1990s* (New York: Routledge, 1990).

[6]See Govert Frank van de Wijngaart, "A Social History of Drug Use in the Netherlands: Policy Outcomes and Implications," *Journal of Drug Issues* 18 (1988): 481–95.

[7]See the first *National Drug Control Strategy* issued by the Office of National Drug Control Policy, Executive Office of the President, in September 1989 (Washington, D.C.: US Government Printing Office, 1989), 11.

[8]See Zimring and Hawkins, *The Search for Rational Drug Control*, 4–21, for a fine analysis of the report and its ideological assumptions.

[9]See Gerald L. Klerman,"Psychotropic Hedonism vs. Pharmacological Calvinism," *Hastings Center Report* 2 (4) (September 1972): 1–3.

[10]See Thomas Szasz, *Our Right to Drugs: The Case for a Free Market* (Greenwood Press, 1992); David Boaz, "The Consequences of Prohibition," in Boaz, ed., *The Crisis in Drug Prohibition*; and the speech delivered by Milton Friedman to the Fifth International Conference on Drug Policy Reform, Washington, D.C., 16 November 1991.

[11]See David A. J. Richards, *Sex, Drugs, Death, and the Law: An Essay on Human Rights and Overcriminalization* (Totowa, N.J.: Rowman and Littlefield, 1982), 157–214.

[12]See, generally, the collection of articles in Thomas H. Murray, Willard Gaylin, and Ruth Macklin, eds., *Feeling Good and Doing Better: Ethics and Nontherapeutic Drug Use* (Clifton, N.J.: Humana Press, 1984), in particular the concluding article by Ruth Macklin, "Drugs, Models, and Moral Principles," 187–213. Also see James B. Bakalar and Lester Grinspoon, *Drug Control in a Free Society* (New York: Cambridge University Press, 1984), and Douglas Husak, *Drugs and Rights* (New York: Cambridge University Press, 1992).

[13]As John Kaplan wrote in 1988, "It is true that if the number of those dependent upon cocaine merely doubled, we would arguably be well ahead of the game, considering the large costs imposed by treating those users as criminals. But what if there were a fiftyfold increase in the number of those dependent on cocaine? We simply cannot guarantee that such a situation would not come to pass; since we cannot do so, it is the height of irresponsibility to advocate risking the future of the nation." See John Kaplan, "Taking Drugs Seriously," *The Public Interest* 92 (Summer 1988): 32–50. Avram Goldstein and Harold Kalant assert more confidently: "There is no reason to doubt that the increased costs to society [of drug legalization] would rival those now attributable to alcohol." See Avram Goldstein and Harold Kalant, "Drug Policy: Striking the Right Balance," *Science* 249 (28 September 1990): 1513–21.

[14]See Andrew Weil, *The Natural Mind: An Investigation of Drugs and the Higher Consciousness* (Boston: Houghton Mifflin, 1972, revised edition 1986), 29. Weil credits Timothy Leary and Richard Alpert with first recognizing the importance

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of these two variables. The significance of "set and setting" is examined at length in Norman E. Zinberg, *Drug, Set, and Setting: the Basis for Controlled Intoxicant Use* (New Haven, Conn.: Yale University Press, 1984).

[15]See, for instance, Lawrence O. Gostin, "Compulsory Treatment for Drug-Dependent Persons: Justifications for a Public Health Approach to Drug Dependency," *Milbank Quarterly* 69 (4) (1991): 561–93.

[16]See Nathan S. Kline, "The Future of Drugs and Drugs of the Future," *Journal of Social Issues* 27 (3) (1971): 73–87; Wayne O. Evans and Nathan S. Kline, eds., *Psychotropic Drugs in the Year 2000* (Springfield, Ill.: Charles C. Thomas, 1971); Alexander Shulgin and Ann Shulgin, *PIHKAL: A Chemical Love Story* (Berkeley, Calif.: Transform Press, 1991); Ronald K. Siegel, *Intoxication: Life in Pursuit of Artificial Paradise* (New York: E. P. Dutton, 1989), 298–317; and Henry B. Clark, *Altering Behavior: The Ethics of Controlled Experience* (Newbury Park, Calif.: SAGE Publications, 1987). A particularly bleak and pessimistic perspective is provided in Morton A. Kaplan, "2042: A Choice of Futures—A Nightmare," *The World & I* (January 1992): 108–115.

[17]Note that the "needle park" experiment in Zurich, Switzerland, from 1990 to 1992 shared little in common with the sort of "supermarket" model developed here. Production and distribution of drugs remained illegal, the place of sale was strictly limited to one small park, and the entire scheme was developed within a fairly strict prohibitionist context. Much the same is true of the "open air" illicit drug markets in many urban ghettos. See Arnold S. Trebach, "Lessons from Needle Park," *The Washington Post,* 17 March 1992.

[18]See David T. Courtwright, *Dark Paradise: Opiate Addiction in America before 1940* (Cambridge, Mass.: Harvard University Press, 1982); and see Ethan A. Nadelmann, "Historical Perspectives on Drug Prohibition and its Alternatives," *American Heritage* (forthcoming).

[19]See, for instance, Michael R. Aldrich, "Legalize the Lesser to Minimize the Greater: Modern Applications of Ancient Wisdom," *Journal of Drug Issues* 20 (1990): 543–53.

[20]Controlled consumption of heroin is examined in Zinberg, *Drug, Set and Setting.* Controlled consumption of cocaine is examined in Dan Waldorf, Craig Reinarman, and Sheila Murphy, *Cocaine Changes: the Experience of Using and Quitting* (Philadelphia: Temple University Press, 1991), and in Peter Cohen, *Cocaine Use in Amsterdam in Non Deviant Subcultures* (Amsterdam: Instituut voor Sociale Geografie, Universiteit van Amsterdam, 1989).

[21]See Stanton Peele, *Diseasing of America: Addiction Treatment Out of Control* (Lexington, Mass.: Lexington Books, 1989), who further observes that most drug abusers eventually quit or curtail their destructive behavior without resort to conventional treatment programs. Also see Charles E. Faupel, *Shooting Dope: Career Patterns of Hard-Core Heroin Users* (Gainesville: University of Florida Press, 1991).

[22]US Department of Justice, Bureau of Justice Statistics, *Sourcebook of Criminal Justice Statistics—1990* (Washington, D.C.: US Government Printing Office, 1991), 347; and US National Institute on Drug Abuse, *National Household Survey on Drug Abuse: Highlights 1988* (Washington, D.C.: Department of

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Health and Human Services, Alcohol, Drug Abuse and Mental Health Administration, 1990), 8.

[23]*The Gallup Poll Monthly,* Nos. 288 and 303, reprinted in *Sourcebook of Criminal Justice Statistics—1990,* 347.

[24]Ibid.

[25]*National Household Survey on Drug Abuse: Highlights 1988,* 44.

[26]Ibid., 8, 45–50.

[27]Ibid., 17–22.

[28]In a nationwide poll commissioned by Richard Dennis and the Drug Policy Foundation, 4 percent of the 1401 respondents said that they would be "very likely" to try marijuana if it were legal, 6 percent said they would be "somewhat likely," 8 percent said "not very likely," and 81 percent said "not at all likely." Asked the same question about the legalization of cocaine, 2 percent said they would be "very likely" or "somewhat likely," 4 percent said "not very likely," and 93 percent said "not at all likely." Similarly, in the annual survey of American high school students conducted by the Monitoring the Future Project at the University of Michigan, 73 percent of respondents said they would not use marijuana even if it were legal, 11 percent said they would use it about as often as they do now, or less, 7 percent said they might try it, and only 3 percent said they would use it more often than at present. See Lloyd D. Johnston, Patrick O'Malley, and Jerald G. Bachman, *Drug Use Among American High School Seniors, College Students and Young Adults, 1975–1990* (Rockville, Md.: National Institute on Drug Abuse, 1991), 141–42.

[29]See Richard H. Blum & Associates, *Society and Drugs* (San Francisco: Jossey-Bass, 1969), 25–44.

[30]See National Research Council, National Academy of Sciences, *Evaluating AIDS Prevention Programs* (Washington, D.C.: National Academy Press, 1988); and the report by the National Commission on AIDS, *The Twin Epidemics of Substance Abuse and HIV* (Washington, D.C., 1991).

[31]See Thomas Szasz, *Ceremonial Chemistry: The Ritual Persecution of Drugs, Addicts, and Pushers* (Anchor Books, 1975).

[32]See Stanton Peele, *The Meaning of Addiction: Compulsive Experience and Its Interpretation* (Lexington, Mass.: Lexington Books, 1985); and John Booth Davies, *The Myth of Addiction* (Philadelphia, Pa.: Harwood Academic Publishers, 1992).

[33]The Australian policy is analyzed in Robin Room, "The Dialectic of Drinking in Australian Life: From the Rum Corps to the Wine Column," *Australian Drug and Alcohol Review* 7 (1988): 413–37. The British policy is assessed in Arthus Shadwell, *Drink in 1914–1922: A Lesson in Control* (London: Longmans, Green & Co., 1923). The impact of Prohibition on alcohol consumption and alcohol-related ills in the United States is assessed in John P. Morgan, "Prohibition is Perverse Policy: What Was True in 1933 Is True Now," in Krauss and Lazear, eds., *Searching for Alternatives,* 405–23; Mark Thornton, *The Economics of Prohibition* (Salt Lake City: University of Utah Press, 1992); and Jeffrey A. Miron and Jeffrey Zweibel, "Alcohol Consumption during Prohibition," *American Economic Review* 81 (2) (1991): 242–47. More generally, see Ethan A. Nadel-

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mann, "Response to Letters," *Science* 246 (1989): 1102–1103; and Harry G. Levine and Craig Reinarman, "From Prohibition to Regulation: Lessons from Alcohol Policy for Drug Policy," *Milbank Quarterly* 69 (3) (1991): 461–94.

[34]Early twentieth-century models of alcohol control, many of which allowed adults to import alcoholic beverages into "dry" locales, are analyzed in Raymond B. Fosdick and Albert L. Scott, *Toward Liquor Control* (New York: Harper & Brothers, 1933); Leonard V. Harrison and Elizabeth Laine, *After Repeal: A Study of Liquor Control Administration* (New York: Harper & Brothers, 1936); and Reginald E. Hose, *Prohibition or Control? Canada's Experience with the Liquor Problem, 1921–1927* (New York: Longmans, Green & Co., 1928). The modification in F.D.A. policy is discussed in James H. Johnson, *How to Buy Almost Any Drug Legally Without a Prescription* (New York: Avon Books, 1990).

[35]See, for instance, David Dixon, *From Prohibition to Regulation: Bookmaking, Anti-Gambling, and the Law* (Oxford: Clarendon Press, 1991).

[36]US Department of Justice, Bureau of Justice Statistics, "Drugs and Jail Inmates, 1989" (August 1991), 1, 9.

[37]See Mark H. Haller, "Bootleggers as Businessmen: From City Slums to City Builders," in David E. Kyvig, ed., *Law, Alcohol, and Order: Perspectives on National Prohibition* (Westport, Conn.: Greenwood Press, 1985), 139–57.

[38]See D. M. Warburton, "Internal Pollution," *Journal of Biosocial Science* 10 (1978): 309–19; and Ruth Cooperstock, "Current Trends in Prescribed Psychotropic Drug Use," in *Research Advances in Alcohol and Drug Problems* 3 (1976): 297–316.

[39]Some of these issues are considered in John P. Morgan and Doreen V. Kagan, eds., *Society and Medication: Conflicting Signals for Prescribers and Patients* (Lexington, Mass.: Lexington Books, 1983).

[40]But also see Chester N. Mitchell, "Deregulating Mandatory Medical Prescription," *American Journal of Law and Medicine* 12 (2) (1986): 207–39.

[41]See Peter Temin, *Taking Your Medicine: Drug Regulation in the United States* (Cambridge, Mass.: Harvard University Press, 1980), and Peter Temin, "The Origin of Compulsory Drug Prescriptions," *Journal of Law and Economics* 22 (April 1979): 91–105.

[42]See Sam Peltzman, "The Health Effects of Mandatory Prescriptions," *Journal of Law and Economics* 30 (October 1987): 207–38, and Sam Peltzman, "By Prescription Only . . . or Occasionally?" *AEI Journal on Government and Society* (3/4) (1987): 23–28.

[43]Peter Temin, "Costs and Benefits in Switching Drugs from Rx to OTC," *Journal of Health Economics* 2 (1983): 187–205.

[44]See the excellent drug education text by Andrew Weil and Winifred Rosen, *Chocolate to Morphine: Understanding Mind-Active Drugs* (Boston: Houghton Mifflin, 1983). Also see David F. Duncan, "Drug Abuse Prevention in Post-Legalization America: What Could It Be Like?" *The Journal of Primary Prevention* 12 (4): 317–22; I. Clements, J. Cohen, and J. Kay, *Taking Drugs Seriously: A Manual of Harm Reduction Education on Drugs* (Liverpool: Healthwise, 1990); David F. Duncan and Robert S. Gold, *Drugs and the Whole Person* (New

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York: Macmillan, 1985); and Ruth C. Engs, *Responsible Drug and Alcohol Use* (New York: Macmillan, 1979).

[45]The efficacy of antismoking campaigns is discussed in Kenneth E. Warner, "The Effects of the Anti-Smoking Campaign On Cigarette Consumption," *American Journal of Public Health* 67 (1977): 645–50; and, by the same author, "Effects of the Anti-Smoking Campaign: An Update," *American Journal of Public Health* 79 (1989): 144–51. Also see Martin Raw, Patti White, and Ann McNeill, *Clearing the Air: A Guide for Action on Tobacco* (London: British Medical Association, 1990). The Partnership's advertisements are evaluated favorably in the Committee on the Value of Advertising, *What We've Learned About Advertising from The Media-Advertising Partnership for A Drug-Free America* (New York: American Association of Advertising Agencies, 1990). More critical analysis is provided in Richard Blow, "How to Decode the Hidden Agenda of the Partnership's Madison Avenue Propagandists," *Washington City Paper* 11 (49) (6–12 December 1991): 29–35; Cynthia Cotts, "Hard Sell in the Drug War," *The Nation* 254 (9) (9 March 1992): 300–302; and Lynn Zimmer, "The Partnership for a Drug-Free America and the Politics of Fear," paper delivered to the Fifth International Conference on Drug Policy Reform, Washington, D.C., 15 November 1991.

[46]See "How to Launch a Nationwide Drug Menace," in Edward M. Brecher and the Editors of Consumer Reports, *Licit and Illicit Drugs* (Boston: Little, Brown and Co., 1972).

[47]See "The Promise of Prozac," *Newsweek,* 26 March 1990; Fran Schumer, "Bye-Bye, Blues: A New Wonder Drug for Depression," *New York,* 18 December 1989; and the more balanced "Beating Depression," *U.S. News & World Report,* 5 March 1990.

[48]See F. Earle Barcus and Susan M. Jankowski, "Drugs and the Mass Media," *Annals of the American Academy of Political and Social Science* 417 (1975): 86–100; Patrick T. MacDonald and Rhoda Estep, "Prime Time Drug Depictions," *Contemporary Drug Problems* 12 (1985): 419–37; William Braden, "LSD and the Press," in B. Aaronson and H. Osmond, eds., *Psychedelics* (New York: Doubleday, 1970); Jock Young, "Drugs and the Mass Media," *Drugs and Society* 1 (November 1971): 14–18; and Craig Reinarman and Harry G. Levine, "Crack in Context: Politics and Media in the Making of a Drug Scare," *Contemporary Drug Problems* 16 (1989): 535–77.

[49]478 U.S. 328, 92 L. Ed. 266, 106 S. Ct. 2968 (1986).

[50]See Sylvia A. Law, "Addiction, Autonomy and Advertising," *Iowa Law Review* 54 (1992); and Peter Hirsch, "Advertising and the First Amendment," in Trebach and Zeese, eds., *New Frontiers in Drug Policy,* 404–407.

[51]See Joe B. Tye, Kenneth E. Warner, and Stanton A. Glantz, "Tobacco Advertising and Consumption: Evidence of a Causal Relationship," *Journal of Public Health Policy* 8 (1987): 492–508. The debate over tobacco advertising is aired in *Advertising of Tobacco Products: Hearings before the Subcommittee on Health and the Environment of the Committee on Energy and Commerce,* House of Representatives, 99th Cong., 2nd Sess. (1986) (Serial No. 99–167). The debate over alcohol advertising is aired in *Alcohol Advertising: Hearing Before The Subcommittee on Children, Family, Drugs and Alcoholism of the Committee on*

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*Labor and Human Resources,* United States Senate, 99th Cong., 1st Sess. (1985) (S. Hrg. 99–16), and *Beer and Wine Advertising: Impact of Electronic Media: Hearing Before the Subcommittee on Telecommunications, Consumer Protection, and Finance of the Committee on Energy and Commerce,* House of Representatives, 99th Cong., 1st Sess. (1985) (Serial No. 99–16).

[52]See Alison Masson and Paul H. Rubin, "Plugs for Drugs," *Regulation* (September/October 1986), 37–53, which argues for fewer restrictions on prescription drug advertising.

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*Jerome H. Skolnick*

# Rethinking the Drug Problem

WHEN FIRST DELINEATED in the late nineteenth century, Tourette's syndrome was regarded as a "moral" disease, an expression of deliberate mischievousness or weakness of the will. In a sudden reversal in the 1960s, when it was discovered that the drug haloperidol could suppress Tourette's symptoms, including involuntary twitching and grimacing, the disease came to be understood "as the result of an imbalance of a neurotransmitter, dopamine, in the brain." In a recent article, the neurologist Oliver Sacks discussed Tourette's as having an extraordinarily complex etiology and cure. Sacks argues, however, that no single perspective—biological, moral-social, or psychological—adequately captures the full meaning and impact of the disease.[1]

The etiology and solution to the American drug problem is possibly even more complex than that of Tourette's syndrome. Yet it has been defined at the national level as primarily a moral challenge. In September 1989, the Bush administration published its first *National Drug Control Strategy*, which set a tone and direction for drug policy which has continued throughout the Bush presidency. (Another *Strategy* was published in January 1992 with only a slightly different ordering of priorities.) The use of any drug, in whatever quantity, was attributed to the deficient moral character of individuals, or weakness of will. Drug use was said to "degrade human character," while a good society "ignores its peoples character at its peril."

The high priority accorded repressive law enforcement seemed to flow naturally from the moralistic attitudes toward drug use and the

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role of government as expressed in the 1989 *Strategy*. Adopting the "war on drugs" as its overriding metaphor, the 1989 *Strategy* fulfilled the metaphor's promise by advocating a vast expansion of the apparatus of social control—particularly of law enforcement and prisons—into what resembles a semimartial state. Introducing the 1989 *Strategy* to America on national television, President Bush proposed that the federal government increase spending to combat drugs by $1.5 billion for enforcement and $1.5 billion for interdiction, but only by $321 million for treatment and $250 million for education. The *Strategy* advocated that billions more be spent by the states, particularly to expand the criminal justice system.

While acknowledging that there is no easy, or even difficult, solution to the American drug problem, I shall argue that, like the shift in understanding Tourette's syndrome, we need a sharp reversal in our thinking regarding drugs, from a perspective centered on moral failure to a broader and more complex etiology highlighting public health and underlying social issues. The militaristic approach is, in any case, programmed to fail. Persistent dilemmas and paradoxes will undermine the capacity of law enforcement officers, at any level, to solve the drug problem.

Working narcotic police understand the limitations of law enforcement, perhaps more than anyone. I asked an experienced New York narcotics officer, a trainer of undercover operatives, whom I accompanied in 1990 to observe the drug dealing scene in New York City's Washington Heights (a major marketing center for crack cocaine), how effective narcotics enforcement was in interfering with cocaine trafficking. His succinct and evocative reply: "We're like a gnat biting on a horse's ass."

The drug problem has two facets: one is abuse and addiction of both legal and illegal drugs; the second is the crime and violence connected to illegal drug use and sale. The administration's approach to expand law enforcement in an unprecedented way has had little impact on either of these problems—except to worsen street violence—because it ignores or does not appreciate the imperatives driving people to use and sell illegal drugs; it underestimates the dilemmas faced by law enforcement in controlling the distribution and use of drugs; it is insensitive to the social and economic underpinnings of drug marketing and use in the United States; and it

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is oblivious to the implications of a war on drugs for the character of the nation.

## DRUGS: NATURAL CRIME OR VICE?

The Bush administration's approach is built on the premise that drug dealing and use is something morally repugnant in and of itself; the solutions that flow from this premise treat people's involvement in drugs as major crimes which must be punished severely. This vision has, of course, serious implications for the workings of our criminal justice system at every level, for the police, the courts, and the prisons. Criminological theorists classically distinguish between "natural" and "regulatory" conceptions of crime. A "natural" conception of crime "embodies a sense of an act that is deeply wrong, that evokes strong communal disapproval, and that is thought to deserve, indeed to call for, a punitive sanction.[2] Ordinarily then, when we think of crime we think of homicide, rape, and assault. We think of these because all are "natural" wrongs, *mala in se*, acts that we understand, almost intuitively, to be wrong in themselves.

By contrast, under a "regulatory" conception, crime is not grounded in moral intuition. It is simply conduct prohibited by a legislature to which penalties are attached. For example, in England the law requires automobiles to drive on the left, while in the United States we drive on the right. Similarly, it might be considered *mala prohibitum* to accept bets on horse racing in a city where off-track betting is illegal (for example, New York) because accepting these bets does not conform to the regulations under which legal horse race betting is permitted. In neither of these cases, however, could the conduct that is prohibited be considered *mala in se*.

A key question that any drug strategy must address is whether the sale or use of drugs is more comparable to illegal betting (use) and bookmaking (sale) or to armed robbery and homicide. How one answers that question will in large part determine one's assessment of the nation's drug control policy. The *Strategy* rests on the moral vision that not only the sale but also the use of illegal drugs is *mala in se*. The *Strategy* accordingly advocates expanding and reshaping the criminal justice system "in an unprecedented way" with not only more police, but more "jails, prosecutors, judges, courtrooms, prisons and administrative staff."[3] The criminal justice system has, in

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fact, become a growth industry, yet with not nearly enough capacity to contain the more than one million inmates already incarcerated.

From the perspective of the *mala in se* theorist, environmental causes of crime and drug use are largely irrelevant, practically invisible. Since individual moral failure, or the failure of will, activates the drug problem, environmental or medical causes—poverty, unemployment, family breakdown, addiction—need not be given high priority. Punishment thus becomes the primary and preferred response. From this perspective it makes sense to stigmatize the casual user as the root villain of the drug problem, since without the casual user, the seller would presumably disappear.[4]

But is the casual user the root of the drug problem? The 1989 *Strategy's* statistical analysis suggests that attributing the drug problem to the casual user rather than the addict is a moral judgement, not an analytical one. The *Strategy* itself begins with good news. Citing a July 1989 survey by the National Institute on Drug Abuse (NIDA), the *Strategy* reports that "current use of the two most common illegal substances—marijuana and cocaine—is down 36 and 48 percent respectively."[5] But it quickly moves to the bad news. Drug related crime and violence continue to rise, the *Strategy* points out, and the threat drugs pose to public health has never been greater because drugs are cheap and "available to almost everyone who wants them."[6]

Who wants drugs? The 1992 *Strategy* acknowledges that the "drug war" is a "two-front" affair.[7] It takes credit for declining use by casual and younger users but sadly reports increasing use by addicted users and those over 35. In actuality, this pattern occurred in 1989 as well. According to an earlier self-report study, casual users never did use much of the total cocaine consumed in the United States. The National Narcotics Intelligence Consumer Committee found that "heavy users" comprised 6.9 percent of the user population, yet consumed 63 percent of the cocaine in this country.[8]

This pattern is probably true of most drugs, including alcohol. One report, for example, shows that 10 percent of the population uses 57 percent of the alcohol, 20 percent of the population uses 78 percent.[9] Moreover, if as the *Strategy* reports, casual use is declining while demand for drugs rises or remains about the same, it seems clear that the addict, not the casual user, is the chief source of demand for cocaine.

Nevertheless, casual use rather than addiction is the focal point of the *Strategy*. The theory plays out something like this: addicts need

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treatment, but they do not contribute much to the spread of drug use. An addict is a "bottomed-out mess" and his or her drug use is therefore "not very contagious."[10] But the casual user is an attractive person "likely to have a still-intact family, social and work life."[11] More attractive than the addict, the casual user sets a bad and appealing example; therefore, his drug use "is *highly* contagious."[12]

Since, however, casual use seems to be declining, and since addicts consume most of the drugs consumed, including alcohol, a focus on the casual, more moderate, user can scarcely be justified. How can we account for it? Three possible reasons come to mind. First, it virtually insures a measure of success, since casual drug use seems to be flagging anyhow. Second, denunciation of the casual user, who is more likely to be white and middle class, relieves the administration of accusations that the law enforcement side of the war on drugs will surely turn out to be disproportionately a war on minority sellers and users, which it surely will be. Finally, a focus on the addict would shift the priorities of drug policy away from police and punishment to treatment, rehabilitation, AIDS research, and the social and economic conditions under which treatment is most likely to work.

Yet casual use of drugs and alcohol is fairly commonplace in American society—enough so that there is almost intuitive agreement that these acts should be heavily punished. If casual use can be shown to have a practical, harmful effect, however, even if not a direct one—i.e., the "contagious" spread of the drug "disease"—the more persuasive is the justification for cracking down on an activity considered to be immoral.

The disease metaphor implies such a justification, although scarcely a compelling one. The casual user's supposed propensity to "infect" others becomes the reason for cracking down. Use, it is assumed, must inevitably lead to abuse. In actuality, the relation between use and abuse depends on the drug, the nature of the user, and the circumstances under which it is consumed. But a moralistic stance easily escalates into a legalistic one collapsing "use" with "abuse." Thus, all marijuana users become, by that definition, immoral abusers who deserve punishment.

### *Alternative views:* mala prohibitum

Those who believe that drug use is *mala prohibitum* fall into two basic camps. One regards drug use in classic libertarian terms, as a

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private matter. This view is grounded in John Stuart Mill's theory of individual liberty. Mill feared the tyranny of the majority which he described as "the tyranny of the prevailing opinion and feeling."[13] He argued that society has a "tendency to impose, by other means than civil penalties, its own ideas and practices as rules of conduct on those who dissent from them." Mill believed in the sanctity of the individual, in individual independence. Most of all he feared the tendency of collective opinion to *compel* others "to fashion themselves upon the model of its own."

Mill did not deny that collective opinion had a legitimate need to interfere with individual independence. He believed that unless society found the proper limit and maintained it against encroachment, the result would be a form of political despotism. This limit is widely known among philosophers as the "harm principle." The enduring influence of *On Liberty* and its harm principle is derived less from some exquisite utilitarian summation than from Mill's intuitions about the despotic potential of government. "The only purpose for which power can be rightfully exercised over any member of a civilized community, against his will," Mill says, "is to prevent harm to others."[14] Mill did not oppose persuading, entreating, or remonstrating with people who engage in admittedly self-destructive conduct. He believed that the criminal law, the power of government, should not be used to deter and to punish individuals in that part of conduct which "merely concerns himself."

Assuming the validity of the harm principle, what standard or principle should we employ to decide whether a particular line of potentially harmful conduct—smoking cigarettes, snorting cocaine, eating to obesity—is of sufficient concern to others to warrant the imposition of a criminal penalty? Mill is himself not entirely clear on this point, but he does make two observations which suggest how it is that such political opposites as William Buckley, Milton Friedman, and the American Civil Liberties Union can agree that drug use ought to be decriminalized.

Mill strongly opposed government interference. He believed in competition, and in competitive examinations, even though the losers might be hurt. In general, he believed in free trade and opposed governmental regulation of advertising. Nor could he be considered a powerful advocate of consumer protection. Indeed, the harm principle was for him not an invitation for the government to act

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when conduct is harmful; rather, it is a limiting principle—the government should not act unless there is demonstrable harm to others.

Nevertheless, Mill did not oppose and even encouraged government regulation where appropriate. The state of Maine had passed a 19th-century prohibition statute, and the "Maine Law" figures prominently in Mill's discussion of liberty. He recognized that those who sold alcoholic beverages—"strong drink" as he called it—had an interest in promoting sales and, contrary to popular assumptions about Mill, he was not at all opposed to regulating them. On the contrary, he saw their interest in promoting intemperance as a "real evil," justifying State restrictions.[15]

Mill, furthermore, uses the example of drunkenness to illustrate the boundaries of the harm principle. Whether someone becomes drunk or not is their business. When, however, under the influence of alcohol, the drunken person commits an act of violence against another, it becomes the government's business. Then, Mill writes:

> I should deem it perfectly legitimate that a person, who had once been convicted of any act of violence to others under the influence of drink, should be placed under a special legal restriction, personal to himself; that if he were afterwards found drunk, he should be liable to a penalty, and that if when in that state he committed another offense, the punishment to which he would be liable for that other offense should be increased in severity.[16]

In sum, the key distinction for those who stand by the harm principle is between private and public space. Mill believed that individuals should be free to gamble in their own homes or private clubs, but that public gambling should not at all be permitted.[17] A Millian liberal distinguishes between being in a state of intoxication in the privacy of one's home, thereby doing whatever harm intoxication does to oneself; and driving on public roads under the influence of drugs or alcohol. A liberal opposes, on principle, as "legal paternalism" any form of coercive legislation that seeks to protect individuals from self-inflicted harm.

A second *mala prohibitum* view regards drug use as at worst undesirable, unfortunate, even deviant, but not necessarily so socially harmful as to justify its characterization as a crime. How we should deal with it is less a matter of the principled relationship between the

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government and the individual than a weighing of the costs and benefits of one policy over another. In this view, drug use should be regulated, not because it is a serious criminal offense, but because drug use entails external costs that society must bear. This position could be termed "post-Millian" in that it calculates the interests of society rather than the individual. This pragmatic position balances the costs against the benefits of a proposed policy. The Millian vision is broadened to include a plurality of others, including costs to community and public safety. Since the morality of a line of conduct is not dispositive, proponents might *entertain* legalization of drugs, as does George P. Schultz, who as Secretary of State led the Reagan Administration's overseas crop eradication program.[18] Even Milton Friedman and William Buckley increasingly make their arguments based on the social consequences of criminalization rather than on individual freedom alone.

*The Consequential Critique*

How should we think about drugs? If one accepts the underlying assumptions of the Bush administration's *Strategy*, it is difficult to argue with its combination of unprecedented punishment and moral regeneration. But if one rejects, or is even unsure of, the underlying assumptions and perceptions of the problem, we need to ask how well its proposals will work and whether alternative policies might work better, and at less cost to the values of a free society.

There is much disagreement, especially within the policy-making and academic communities, over the appropriate definition of and response to the drug problem. Advocates of repression have gained their share of supporters as the social acceptability of drug use has shifted dramatically toward moral intolerance over the past twenty years. In an anticrime climate, politicians are responding to an electorate demanding higher penalties for drug dealing and use. However, these views, while increasingly popular, by no means represent a consensus.

Many people maintain quite different attitudes toward drug use, depending on the levels, time, place, and occasion for intoxication. They are ambivalent about the moral blameworthiness of private drug use and even of addiction, should it occur. As Herbert Packer once observed:

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> The extent of disagreement about moral judgements is an obvious reason for hesitancy about an automatic enforcement of morals. There have been monolithic societies in which a static and homogeneous ethnic, religious, and class structure conduces to widely shared acceptance of a value system. But that is hardly a description of the reality of twentieth-century American society, or of its pluralistic and liberal aspirations. . . . We don't begin to agree about the "morality" of smoking, drinking, gambling, fornicating, or drug-taking, for example, quite apart from the gap between what we say and what we do. The more heterogeneous the society, the more repressive the enforcement of morals must be.[19]

If, as Packer suggests, there is no consensus that intoxication—absent tangible harm to others—is inherently despicable, then we have no intuitive sense of deserved retribution. This does not imply that drug use should never be penalized, but rather that consequentialist arguments stressing the impact of deterrence, incarceration, and rehabilitation will make more sense than moralistic ones. People will ask, "What works and what doesn't work and why?"—rather than assuming that drug use of any kind, by any consenting adult, is inherently evil. So the question becomes, how well do the law enforcement forces arrayed against drug use and dealing work in practice?

## THE DILEMMAS OF LAW ENFORCEMENT

One would think that the heightened penalties and huge infusions of resources we have devoted to drug enforcement at the state and national levels would long ago have dried up the drug trade. Yet that did not happen during the 1980s and early 1990s. New York City arrest statistics tell the story. Despite efforts by dedicated and resourceful police officers, the New York narcotics scene seemed impervious to their intervention. Arrests increased every year in New York City following the introduction of crack cocaine in 1984. There were 45,000 arrests in that year, rising to 58,000 in 1986, 79,000 a year later, 89,000 in 1988 and more than 100,000 by the end of the decade. I asked then New York narcotics Chief John Hill whether these increasing arrests have been effective in stopping the problem. Chief Hill was less colorful in his language than the street detectives with whom I had been riding, but equally pessimistic. "The easiest

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thing to do is make an arrest," he said to me. "The hardest thing is to stop it. Enforcement will never stop it."

The "get tough" approach is essentially based on a theory of deterrence that sounds superficially persuasive. If we raise the cost of selling and using drugs by increasing penalties, it is assumed, we will drive out dealers and sellers. In the abstract, the theory seems to make sense. In practice, when we delve more deeply into its workings, we can understand how and why it works far less efficiently than assumed, or, paradoxically, may even worsen the drug problem.

*Supply and Demand*

The sale of drugs is economically motivated, and is thus responsive to market incentives and disincentives. The question remains as to how these operate in the context of the drug trade. The 1989 *Strategy* acknowledges that "despite interdiction's successful disruptions of trafficking patterns, the supply of illegal drugs entering the United States has, by all estimates, continued to grow." [20] Why should that have happened? One reason is that demand generates supply for drugs. Demand for drugs in the United States and Europe contributed to the growth of the cocaine business in Colombia and Peru, the world's main growers of coca.[21] A rise in production increases supply, which causes a drop in price. Price reduction in turn further invigorates demand, which stimulates the whole cycle again.

*Efficient Suppliers: Survival of the Fittest*

"As we have expanded our interdiction efforts," the 1989 *Strategy* states, "we have seized increasing amounts of illegal drugs. Stepped up interdiction has also forced drug traffickers to make significant operational changes. . . . Every time we disrupt or close a particular trafficking route, we have found that traffickers resort to other smuggling tactics that are even more difficult to detect."[22] This is undoubtedly true, but it argues as well against, rather than for, stepped-up interdiction.

More recently, the 1992 *Strategy* took pride in record drug seizures. It reported that in May 1991, US Customs inspectors seized a record 1,080 pounds of heroin in a cargo container arriving at San Francisco. In July 1991, the US Navy intercepted the *Lucky Star* in the Pacific. The ship was escorted to Pearl Harbor, where Customs agents seized a record 73 tons of hashish. In November 1991, US

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Customs and DEA agents seized, in the second largest cocaine seizure in US history, 23,641 pounds of cocaine concealed in concrete fence posts that were being delivered from Venezuela to Miami.

Should record seizures be considered an accomplishment or a concern? If we interpret the record seizures as a cutoff of the drug supply to the United States, then they are a triumph. If we believe, however, as most observers of the drug trade do, including law enforcement observers, that we interdict around 10 percent to, at most, 20 percent of the shipments of drugs to the United States, these record seizures suggest the enormity of the drug supply and the relatively efficient organization of the suppliers.

As these more efficient producers exercise greater control over markets, they may exercise monopolistic control to raise prices. Law enforcement officials may mistakenly assume that rises in the street price of drugs are a result of efficient interdiction strategies. In actuality, higher prices may bring greater profits to efficient suppliers.

Approximately 60 percent of the world's cocaine is grown in the Peruvian Andes and processed in Columbia. Late in 1991, the United States assisted the Peruvian government in asserting control over airspace by introducing and manning new radar stations at airfields at Andoas and Iquitos, two river towns in the vast Amazonian region. In the first three months of 1992, nine planes were intercepted, forcing six to land and three to crash. Yet an estimated six planes a day leave Peru carrying coca base north.[23] Thus, only nine planes out of more than 1,000, approximately 1 percent, were intercepted. Even if ten or fifteen times that number were to be intercepted, there would be minor interference with the overall enterprise. Practically, interdiction is said to "introduce another level of risk to the individual drug smuggler."[24] Yet, while defending interdiction, the 1989 *Strategy* concedes that "interdiction alone cannot prevent the entry of drugs or fully deter traffickers and their organizations."[25]

Quite an understatement. In reality, interdiction efforts face what might be called "the Darwinian Trafficker Dilemma." Interdiction undercuts the marginally efficient drug traffickers and their operations, while the fittest—the best organized, the most corrupting of authorities, the most ruthless and efficient, survive. As Stephen G. Trujillo, a former Army Ranger, Green Beret, and enforcement specialist with the Drug Enforcement Administration's Operation Snowcap wrote of his experiences the day after President Alberto

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Fujimori suspended the Peruvian Constitution with the army's backing, in effect, a right wing military coup: Paradoxically, the destruction of dozens of cocaine labs by US and Peruvian forces has only encouraged the coca processors to be more efficient. Smaller, more decentralized labs are processing purer cocaine in the impenetrable jungles.[26]

*The Permeability of Borders*

Rand Corporation economist Peter Reuter, who studied the question of border permeability for the Department of Defense, concluded that "the U.S.-Mexico border can be crossed at many points. . . and a high value crossing can be accomplished very suddenly by a single individual in a large crowd of similar individuals. . . . "[27] Thus, the sheer number of people who make border crossings each year aggravates the problem of penetrable borders.

When the Reagan Administration's war on drugs cracked down on Florida as the main entry point for cocaine, drug smugglers moved the main supply route of the product from Florida to California. I spent four days reviewing the border situation in California with the assistance of the California State Narcotics Agency. They assigned a Mexican-American agent to me in Los Angeles, to help me understand the drug scene in southern California. Through his assistance, I was able to observe DEA operations, and to interview local and federal police. As with most narcotics police, they seemed to be intelligent, energetic, and well supplied with equipment. I was told that 60 percent of the narcotics entering the United States passed through California. The Mexican border posed a major, and virtually insolvable problem, however. The Mexican-American state narcotics agent who was my guide, and who had been raised in a Los Angeles gang neighborhood, took me to a Mexican restaurant for lunch, told me about his childhood, his entry into the police, looked at me earnestly, and said with some exasperation: "Look professor, 400,000 of my people cross the border illegally every year. How can you stop a much smaller number who carry a kilo or two of cocaine on their back?"[28] None of the record seizures reported in the 1992 *Strategy*, it might be noted, were at the Mexican border.

What is the administration's justification for interdiction efforts? The 1989 *Strategy* claims that interdiction "has major symbolic and practical value."[29] The symbolic value is gained from showing

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foreign governments and trafficking organizations our commitment to combating the drug trade. But symbolism seems an odd reason for policy, resting neither on practical achievement nor on canons of justice. Still, much of the proposal is grounded on symbolic themes and on the appearance of determination, rather than on a careful assessment of short and long range outcomes.

Interdiction advocates vastly overestimate the costs that interdiction imposes on drug trafficking. Interdiction is supposed to reduce street sales by increasing smuggling costs—in effect, taxing smuggling—and thus raising the street price. This assumes that smuggling costs constitute a significant percentage of street price. But that simply is not true. It is relatively cheap to produce and refine a kilo of cocaine, perhaps around $1,000 for a kilo that might eventually retail for $250,000 when broken down into quarter or even eight gram units. Smuggling costs might amount to an additional few percent of the retail price. In actuality, most of the retail price of cocaine is divided among those who distribute it on this side of the border. Rand economist Peter Reuter writes, "Fully 99 percent of the price of the drug when sold on the streets in the United States is accounted for by payments to people who distribute it."[30]

Thus, if a kilo of cocaine retails for $250,000, smuggling costs account for around $2,500. A doubling or tripling of smuggling costs accordingly has a negligible impact on street price. Combined with the vastly increased production which has driven prices down, interdiction has had little, if any, positive effects—and these can be outweighed by the unanticipated side effect of strengthening drug marketing organizations.

*Drug Hardening and Demand Substitution*

When the Nixon administration succeeded in reducing the supply of low potency Mexican marijuana to California in the early 1970s, agriculturally skilled drug entrepreneurs developed a high potency marijuana (sensimilla) industry in Northern California, generating a market for a drug five or more times as potent. This example is illustrative of what might be called "The Drug Hardening Paradox." The more successful law enforcement is at cutting off supply, the more incentive drug dealers have for hardening drugs—i.e., developing varieties that are more potent, portable, and dangerous. Thus, the recent crackdown by state narcotics agents on the California mari-

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juana market has reduced its supply, but crack cocaine has now emerged to replace marijuana. My colleagues and I have interviewed Oakland and south central Los Angeles youngsters who have never used marijuana, but who have used crack cocaine, which has for several years been less expensive and more available on California streets. In sum, law enforcement tactics may create more severe public health problems by generating demand for and production of more potent and dangerous drugs.

A paradox closely related to drug hardening, might be called "The Demand Substitution Paradox." Those who are interested in faster living through chemistry often find it possible to substitute one drug for another. (Most drug abusers usually ingest more than one drug.) Thus, price increases or lack of availability of one drug may activate consumers to seek out cheaper alternative drugs.

In the 1970s, marijuana was the popular drug among students. Today, it is alcohol. Thirty percent of high school seniors reported in 1991 that they had drunk heavily (five or more drinks in a row) at least once in the previous two weeks. Since alcohol is illegal for those under 21, all of this drinking was in violation of the law.

Twenty or thirty years ago, heroin was the "problem" drug in American society.[31] More recently, it has been crack cocaine, which is becoming less popular. At the same time, according to the 1992 *Strategy,* "the price of heroin has dropped, the purity has increased, seizures by law enforcement officials have increased, and there has been an upsurge in heroin emergency room mentions in the first two quarters of 1991—all, it would seem, indicative of a resurgence in drug use."[32] Although heroin users tend to be older, they are also more dangerous to the public health. Heroin is consumed intravenously, and its users are thus more likely to spread the HIV virus.

If we succeed in destroying agricultural drugs through crop destruction efforts in Peru, Bolivia, and Columbia, we could find an increase in the use of alternate drugs and in the supply of synthetic, designer drugs that are more potent and destructive than anything we have yet seen. These include fentanyl, for example, which is around 100 times as powerful as morphine and 20 times stronger than heroin. Fentanyl's medicinal analogs, sufentanyl and alfentanyl, are 2,000 to 6,000 times stronger than morphine. These drugs can produce bizarre, destructive, and unpredictable toxic effects. Fenta-

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nyl may be more widely used than we now know, since it cannot be detected by drug tests.[33]

As demand for particular drugs waxes and wanes based either on fashion or on interdiction, new drugs will be demanded by consumers and supplied by innovative entrepreneurs.

*Corruption*

Whatever the latest trend in drug use, manufacturers, smugglers, and distributors can operate more efficiently by corrupting public officials. Neither the 1989 nor 1992 *Strategy* discuss corruption, another dilemma confronting law enforcement efforts in the war on drugs, although it discusses "turf battles" among federal enforcement agencies.[34] A discussion of interagency rivalry is acceptable because it is a normal and acceptable aspect of bureaucratic processes.[35]

Corruption, on the other hand, is unmentionable. Any strategy, however, which fails to consider the possibility and ramifications of increased corruption in the wake of expanded law enforcement is seriously flawed.[36]

As we attempt to pressure foreign producers, we will have to work with authorities in such countries as Colombia, Bolivia, Panama, and Peru, countries where the bribe is a familiar part of law enforcement. Thus, the State Department's Bureau of International Narcotics Matters found that Jorge Luis Ochoa, a major Colombian drug trafficker, "was able to buy his freedom through the intimidated and vulnerable Colombian judicial system."[37] Concerning Colombia, journalist Tina Rosenberg observed:

> In general, the closer an institution gets to the traffickers, the more corrupt it becomes. Cocaine's new income opportunities for judges have been well documented. Prosecutors are less corrupt, but it is a matter of logistics, not morals: it is simply easier to win cases by bribing judges, or the police. . . . Policemen, the infantry in the war on drugs, are usually young men from slum neighborhoods with third grade educations—exactly the profile of a drug dealer, and the line between the two tends to blur on the job.[38]

No matter how honest US drug enforcement agents operating abroad are, they may find themselves operating in a climate of official corruption. In Peru, police officers bribe their superiors to be transferred to interdiction zones, where illegal landing fees can bring

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$5,000. Peru's Attorney General said in March 1992, "Many policemen, instead of fighting against drug trafficking. . . are involved in it."[39]

Indeed, in Peru, the corruption is so pervasive, and so sinister—the military are also in league with and protective of the drug dealers—as to endanger the safety of American advisers and DEA agents. Stephen Trujullo describes one of several threatening incidents:

> On June 15, 1990, three other DEA advisers and I accompanied the drug police to Tocache, north of the Santa Lucia base. Hovering over the municipal airfield in our helicopters, we caught soldiers red-handed as they transferred a load of cocaine base to a stash house. We landed and chased the fleeing soldiers back to their barracks, only to be surrounded by the remainder of the garrison. The soldiers raised their assault rifles, and their commander ordered us to surrender our weapons. Only the adroit diplomacy of the senior DEA agent saved us.[40]

Domestic police officers are equally susceptible to the temptations of drug money. Unfortunately, we are all too familiar with the legendary narcotics scandals which have plagued police departments in various cities. Perhaps the most famous have occurred in New York City where the Knapp Commission investigations reached both narcotics and other forms of vice. Patrick V. Murphy, a man with a reputation for reform, was recruited as Police Commissioner in New York in the wake of the scandal uncovered by the Knapp Commission. In his autobiography, he writes, "We ultimately discovered that the narcotics units under the previous police administration had made major contributions to the city's drug traffic. It was this area of corruption more than anything else which most shocked me."[41]

Narcotics corruption is not confined to New York City. Deputies in the Los Angeles County Sheriff's Department were recently involved in what *The Los Angeles Times* called "one of the worst corruption cases" in the department's history. Videotapes revealed one deputy hurriedly taking three $10,000 bundles of $100 bills from a dealer's shoulder bag and putting them into his partner's leather briefcase.[42]

Although the possibilities of corruption exist in any form of enforcement against criminal activity, it is particularly in drug enforcement that agents and officers encounter large sums of cash and drugs with great market value. In short, corruption must be counted as one of the anticipated costs of an unprecedented expan-

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sion of drug law enforcement. As Peter Reuter recently summed up the dilemma of corruption, "The incentive to bribe criminal justice officials is positively related to the intensity of enforcement."[43]

*The Explosion of Imprisonment*

The "unprecedented" expansion of police, prosecutors, and prisons implicates a third set of problems related to imprisonment. Attempting to solve the drug problem by imprisoning more drug users and sellers may, paradoxically, worsen the problem at the street level. State and federal prison populations have virtually doubled in the 1980s[44] and the rate of our prison population per 100,000 of total resident population has increased from 96 in 1970 to 228 in 1987.[45] Overcrowded jails and prisons are bulging with newly convicted criminals, and also with criminals whose probation and parole were revoked. In California, for example, the number of parole violators returned to prison between 1978 and 1988 increased by about eleven times.[46]

A likely reason for this rise is the increased frequency with which drug tests are being required of parolees.[47] Revised estimates by the California Department of Corrections project that the state's prison population will grow by more than 50 percent by the year 1994, and that the state will need to build up to twenty prisons to house the expected growth in inmate population.[48] As our advanced drug testing technology consigns more parolees and probationers to prison, we cannot continue to convict and impose longer sentences without building many new prisons.

The Bush administration's drug policy acknowledges this critical lack of prison space. It appreciates that "most state prisons are already operating far above their designed capacity."[49] It also recognizes that "many states have been forced under court order to release prisoners before their terms have been served whenever a court-established prison population limit has been exceeded."[50] The solution, however, is to encourage state governments to persuade their citizens to support new prisons. "The task of building [prisons], remains with state governments, who poorly serve their constituents when prison construction is stalled or resisted."[51]

Yet not a word appears about how to persuade citizens to pay for the continuing and rising expense of maintaining prisons, without raising state taxes to support prison construction. Furthermore, even

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those citizens who demand longer and more certain prison sentences are reluctant to live next door to prisons, which are being built in increasingly remote areas. Highly publicized plans for a 700 bed prison to house convicted Washington, D.C. drug dealers at Fort Meade, Maryland were embarrassingly withdrawn the day after they were announced because "there was too much public resistance,"[52] as there is near urban areas whenever a new prison site is proposed.

*Ineffective Criminal Sanctions*

Even if new prisons could be constructed over financial and community objections, a more fundamental problem is the failure of criminal sanctions to achieve purported goals. One of these is the reform and correction of inmates. Imprisonment is not necessarily stigmatic, nor entirely foreboding for those who sell drugs. My students and I have been interviewing imprisoned drug dealers in California since 1989, and learned that imprisonment may bring a certain elevated "home boy" status, especially for gang youths for whom prison, and prison gangs can become an alternative site of loyalty.[53]

Moreover, imprisonment often reinforces prisoners in their troublesome behavior. Already consigned to the margins of society, prisoners join gangs, use drugs, and make useful connections for buying and selling drugs. Perhaps the penitentiary was once a place for experiencing penance. However, today's correctional institutions, overcrowded with short-term parole violators who have failed their court-mandated drug tests, often serve purposes similar to those advanced by academic and business conventions—as an opportunity for "networking."[54] A recent newspaper survey of prison drug use found that it has become a "major problem," and it cited "threats to prison order, violence among inmates and corruption of guards and other employees" as among the most serious.[55]

President Bush and others have made the incarceration and execution of "drug kingpins" a focus of the drug war. When we succeed in incarcerating drug dealers in prisons, however, we encounter what I think of as the Felix Mitchell Paradox, named in honor of the West Coast's formerly most infamous drug distributor. In the mid-1980s, a federal strike force, with considerable assistance and dogged investigation by an Oakland Police vice squad, succeeded in convicting and imprisoning the East Bay's three leading drug dealers. Among these was the legendary Felix Mitchell, who, the prosecution

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charged, was largely responsible for Oakland's becoming a major drug dispensary, and who received a life sentence without possibility of parole in a federal district court for his drug related convictions.[56] One would expect that confining three leading drug dealers to prison would reduce the violence and other crimes related to narcotics. On the contrary, Oakland has since then experienced a continued increase in narcotics crimes and the absence of any indication that the Oakland residents perceive the community to be safer.[57] The post Felix Mitchell drug related homicide rate has proved especially vexing. Gangs competing for the Mitchell territory accounted for multiple murders, high speed chases, daytime assassinations, four assaults on police officers, and scores of other shootings. It is likely that, for the drug gangs, whatever deterrent value the criminal law has can be outweighed by the profits to be gained through expanding into the market vacuum created by the withdrawal of imprisoned suppliers.

Peter Reuter makes a similar observation about the relationship between violence and market share as an explanation for the District of Columbia's soaring homicide rate. He argues that when the supply of drug dealers exceeds the demand for drugs, "one obvious way to raise earnings is to eliminate the competition through violence."[58] The District of Columbia's soaring homicide rate cannot be attributed to inactivity of the District's police during the 1980s. Only 58 juveniles had been arrested for drug dealing offenses in 1981; by 1987 that figure had reached 1550.[59] In 1981, adult arrests—usually men in their early twenties—totalled 408; by 1987 it was 5,297.[60]

However notorious for drugs and homicides, Oakland, California and Washington, D.C. are scarcely unrepresentative. One can pick up almost any major metropolitan newspaper on any given day and read of drugs and homicide. Drugs and violence have in the 1980s and 1990s become as institutionalized a part of American life and journalism as the Vietnam War was in the 1960s, and as much of a quagmire. Thus, on April 2, 1992, the front page of *The New York Times* carried an article titled "From Queens to Rochester: Adrift in a World of Violence," about an 18-year-old who was arrested in a church, where he had sought sanctuary as a suspect who had killed eight people in four days. The author, Alison Mitchell, had interviewed the suspect's friends and neighbors who spoke to her of "a land in which a teen-ager sold cocaine like candy, putting an 'out'

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sign in his apartment window when he had run out of supplies." Increased criminal sanctions, as in the war on drugs, have had little impact in the cities of America against either drug kingpins and lower level dealers. Stepped-up enforcement has usually encouraged other suppliers to enter the market or amplify their activities through the violent elimination of competitors. It is time to face reality. The drug war has failed.

*What Is to Be Done?*

It is easier to say what is *not* to be done than what is to be. To be avoided are the ineffectual and costly policies and the misinformation of previous decades. When we educate about drugs we need to stress reality and health values. Drug education often poses false polarities. Drugs are either harmless or will "fry your brain." The dangers of marijuana were overstated in the 1950s and 1960s. The absurd overstatements (that marijuana use leads to violent assaults) instead of discouraging use, encouraged false inferences in the opposite direction—that marijuana use posed no dangers. In fact, drug effects and side effects are complex and vary according to the chemical properties of the drug; the setting in which it used; the potency (unfortified wine vs. distilled spirits), the quantity used, the frequency of use, and the biological, psychological, and social circumstances of the user. Many people can control their use of alcohol, cocaine, and marijuana. Others cannot.

Legalization has often been proposed as an alternative to the vast expansion of law enforcement that we witnessed during the Reagan-Bush years. Legalization is no panacea either, however. Questions to be asked about it are: what form would legalization take; are all or only some drugs to be legalized; what would be the costs and benefits and to which groups; and can legalization be reconciled with a positive moral message?

Essentially, legalization implies four models. Under the least restrictive free-market model, every drug, even cocaine and heroin, could be sold as we do aspirin, over-the-counter. The free-market model offers the strongest argument for legalizing. At one stroke, the free market would wipe out smuggling (drugs could be taxed), organized drug syndicates, street sales, and street violence. Scarcely less restrictive is the cigarette paradigm, regulating only as to age of purchaser. Alcohol offers a third, slightly more regulated model,

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while the most restrictive of the legalization models is the prescription drug paradigm, which is already employed for methadone treatment, and for treatment accorded to a vast patient population of users of tranquilizers and sleeping pills.

Marijuana offers the most plausible case for nonprohibition. Were we to regulate marijuana more tightly than we do alcohol, we would end half or more of our current drug arrests without a significant impact on public health. We would expect that more people would use marijuana, but not so many more, given the increasing concern for health and sobriety between the 1960s and the 1990s. None of this will perfectly succeed. The more controls government imposes, the greater the incentives to develop illegal markets. If we allow the sale and use of low potency marijuana, we will stimulate illegal markets in the high potency stuff. If we control sales to youngsters, some will surely buy on the black market, as they already do.

If Cocaine HCL (powder cocaine) were to be legalized, we would generate incentives for producing crack cocaine, that is, purified, heat stable cocaine, suitable for smoking. "Absorbed across the pulmonary vascular bed," explain the neurologists Golbe and Merkin, "it produces a more intense euphoria and more precipitous withdrawal than Cocaine HCL and is therefore more addictive."[61]

There is thus no perfect legalization solution, but the benefits of marijuana legalization seem to outweigh the costs of enforcement. On the other hand, since crack cocaine, heroin, and phencyclidine (PCP) remain inner-city favorites, the actual and symbolic consequences of legalizing these drugs may prove disastrous, possibly generating a sharp rise in use among the truly disadvantaged, especially among teenagers already inclined to use these drugs. To be sure, these drugs are already easily obtainable, though not as easily as they would be under a legalization regime. Reasonable prudence demands that these drugs remain illegal. As John Kaplan observed in opposing cocaine legalization: "If we legalize cocaine now, how long should we wait before deciding whether we made a mistake? And if we decided that we had, how would we go about recriminalizing the drug?"[62]

The issue, however, is not only whether to legalize a drug, but how to influence the message accompanying legalization. Legalization of a vice does not necessarily connote approval or promotion of the activity, although it so often has in the United States. When Prohi-

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bition was repealed, the saloon doors were thrown open. We not only legalized distilled spirits, but the cocktail lounge and a culture of drinking along with it. When our state governments have legalized gambling—lotteries, casinos, and off-track betting—they have also, and shamelessly, promoted gambling. However, it is possible to reconcile legalization with a strong public health message. When the British legalized casinos in 1968, the purpose was to control organized crime. They did not permit casinos to advertise at all, not even with matchbooks or advertisements in the telephone directory.

Similarly, if we eliminated criminal penalties for possession of marijuana, and strictly regulated its sale, such decriminalization would need to be accompanied by a larger moral purpose—to reduce crime and violence, to enhance public health and safety through drug education and treatment, and to invigorate a sense of community. Legalization of marijuana, in sum, need not and should not imply advocacy. On the contrary, the taxed proceeds from such legalization should discourage, even while permitting, use of the drug. A slogan for legal drugs might be: "Never use cigarettes; and if you must use alcohol and marijuana, use moderately."

## A PUBLIC HEALTH/SOCIAL PROBLEMS STRATEGY

On March 12, 1992, *The San Francisco Examiner,* a Hearst newspaper critical of the Bush Administration's war on drugs strategy, praised Dr. Andrew Mecca, director of California's Department of Alcohol and Drug Programs for his new ideas. What are these? Presently, two-thirds of the nearly 13 billion dollars the United States spends waging a war on drugs is allocated to interdiction and law enforcement. Only one-third goes to prevention and treatment. In the *Examiner's* view, and in my own, these priorities should be reversed. Dr. Mecca is taking the right course but is not there yet. With a $1 billion budget to fight drugs, California is allocating 50 percent for enforcement, and 50 percent for treatment and prevention. Nevertheless, this recognition that priorities need to be shifted is the sensible direction in which to move.

I would add, however, that the public health approach needs to be supplemented by a "social problems" dimension critical to understanding the etiology of drug use and the obstacles to successful treatment and prevention. The moralistic stance adopted by the Bush administration in

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its *Strategy* assumes a single minded moral paradigm—drug users and sellers are evil and they must punished. But it ignores key issues: why do some communities produce street drug dealers and street violence, while others do not? How do social, economic, and psychological conditions affect drug use and sale? Why do users ingest crack cocaine? What does it mean to say that it is "addicting?"

Here are some answers: Crack cocaine, like Cocaine HCL, but unlike heroin, is psychologically, but not physiologically addicting. A drug dealer (and former user) whom I interviewed communicated the distinction vividly and clearly in nonmedical terminology:

> It's not addicting like your body craves it. You're not going to get sick... by not smoking. Only thing that craves crack is your mind. It's like an illusion. You hit the pipe you are whatever you want to be.... Say you're into music and you're basing (using crack or its chemical equivalent). You feel like you *are* James Brown or Stevie Wonder or Michael Jackson.

The above description suggests that users ingest drugs to feel euphoric, to take one out of life's circumstances, to overcome despair, hopelessness, and low self-esteem. Such feeling states can occur to individuals within any social group, but they are heightened by joblessness, poverty, and neglect. Thus, the more satisfied and engaged people are with their lives and themselves, the less likely are they to be drawn—regardless of the consequences—to the euphoric feeling states of crack cocaine. A clean and sober addict with a job will be less likely to relapse than one who is unemployed.

Total abstinence—being clean and sober—should be the treatment goal for cocaine and alcohol addictions. Oral methadone maintenance is a less desirable, but necessary, alternative for heroin addicts, especially since heroin addicts, who are physically addicted, typically ingest intravenously, and therefore are at risk for contracting and spreading the HIV virus. Whatever the treatment modality, the more an addict can count on social support through family, friends, a therapy group such as Alcoholics Anonymous, the more likely will the goal of total abstinence be achieved.

The "truly disadvantaged" are less likely to enjoy this sort of social and economic support. Such addicts live in a world—often a housing project—which cues craving as they see drugs being sold and used all around them. Treatment is often unavailable as there are no Betty

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Ford clinics for the desperately poor. It is in this setting, through foot patrol, community policing and community organization, that law enforcement enjoys perhaps its greatest potential.

But even the best organized and most thoughtful local law enforcement strategies are constrained, since those who sell, as well as those who buy, are also responding to underlying economic and social conditions. Terry Williams, a sociologist who spent more than 1,200 hours studying a primarily Dominican drug gang in Washington Heights, whom he called "The Cocaine Kids," portrays them as both antisocial criminals and "struggling young people trying to make a place for themselves in a world few care to understand and many wish would go away." The kids have learned a trade. They know how to buy cocaine, cook it into crack, distribute, and sell it. Williams portrays them as entrepreneurs, interested not only in making money, but also in showing their families and friends that they can succeed at something.[63] And Phillipe Bourgeois, who studied crack dealers in New York's Spanish Harlem, challenges the assertion of culture-of-poverty theorists that the poor are socialized out of the mainstream and have different values. He concludes that:

> On the contrary, ambitious, energetic, inner-city youths are attracted to the underground economy precisely because they believe in the rags-to-riches American dream. . . . Without stretching the point too much, they can be seen in conventional terms as rugged individualists on an unpredictable frontier where fortune, fame and destruction are all just around the corner.[64]

Neither moral exhortation nor an unprecedented expansion of law enforcement, or military intervention can or should be used to address what is essentially a health and social problem. These hard edged responses are costly to our pocketbooks and, worse, are largely counterproductive. Until we redefine the drug problem as a public health and social problem rather than as a moral failure, we will make little headway in promoting the health and public safety of our citizens.

ENDNOTES

[1] Oliver Sacks, "A Neurologist's Notebook," *The New Yorker*, 16 March 1992, 85.

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[2] Hughes, *The Concept of Crime,* in S. Kadish, ed., *Encyclopedia of Crime and Justice* (1983), 294–95. This excellent essay goes on to develop the distinction.

[3] See the first *National Drug Control Strategy* issued by the Office of National Drug Control Policy, Executive Office of the President (Washington, D.C.: US Government Printing Office, 1989), 24. [hereinafter *Strategy*].

[4] Jaynes and Williams, eds., *A Common Destiny: Blacks and American Society* (Washington, D.C.: National Academy Press, 1989), 398.

[5] Sacks, "A Neurologist's Notebook."

[6] *Strategy,* 2.

[7] *National Drug Control Strategy: A Nation Responds to Drug Use* (Washington, D.C.: US Government Printing Office, 1992).

[8] These data are cited in Cloud, "Cocaine, Demand, and Addiction: A Study of the Possible Convergence of Rational Theory and National Policy," *Vanderbilt University Law Review* 42 (1989): 725, 752.

[9] Dean R. Gerstein, "Alcohol Use and Consequences," in Mark H. Moore and Dean Gerstein, eds., *Alcohol and Public Policy: Beyond the Shadow of Prohibition* (Washington, D.C.: National Academy Press, 1981).

[10] *Strategy,* 11.

[11] Ibid.

[12] Ibid.

[13] John Stuart Mill, *On Liberty* (London: Penguin, 1974), 9. (First published in 1859).

[14] Ibid.

[15] Ibid., 170.

[16] Ibid., 167.

[17] Ibid., 170.

[18] Even conservative policy analyst Charles Murray thinks legalization might be the answer to the drug problem. *The New York Times,* 27 November 1989, A15, C14.

[19] H. Packer, *The Limits of the Criminal Sanction* (1968), 265.

[20] *Strategy,* 73.

[21] The notorious Peruvian guerrilla organization, the Shining Path, has become deeply involved in the narcotics business. It serves as a broker for coca growers, collects taxes from traffickers, and protects both from security sources. See, for example, *The New York Times,* 6 December 1989.

[22] *Strategy,* 73.

[23] James Brown, "Fighting the Drug War in the Skies Over Peru," *The New York Times,* 28 March 1992.

[24] *Strategy,* 74.

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[25] *Strategy,* 73.

[26] Stephen G. Trujillo, "Corruption and Cocaine in Peru," *The New York Times,* 7 April 1992, Op-Ed.

[27] P. Reuter, G. Crawford, and J. Cave, "Sealing the Borders: The Effects of Military Participation," in *Drug Interdiction* 18 (1988).

[28] Skolnick, Correl, Navarro, and Raab, *The Social Structure of Street Drug Dealing,* California Bureau of Criminal Statistics Forum (Office of the Attorney General, 1988) [hereinafter *Social Structure*].

[29] *Strategy,* 74.

[30] Peter Reuter, "Can The Borders Be Sealed?" *The Public Interest* (Summer 1988): 56.

[31] For a thorough analysis of the problems posed to American society by heroin, see J. Kaplan, *Heroin: The Hardest Drug* (1983).

[32] *Strategy* (1992), 11.

[33] *Journal of the American Medical Association,* 12 December 1986, 3061.

[34] *Strategy* (1992), 11.

[35] The *Strategy* suggests that "we should be extremely reluctant to restrict within formal and arbitrary lines" the extent of bureaucratic bickering when it is attributable to the "overriding spirit and energy of our front-line drug enforcement officers. . . " *Strategy,* 8.

[36] For an account of rampant corruption in the Drug Enforcement Agency, see *The New York Times,* 17 December 1989.

[37] US Department of State, Bureau of International Narcotics Matters, *International Narcotics Strategy,* Report 86 (March 1988).

[38] Rosenberg, "The Kingdom of Cocaine: A Report from Colombia," *New Republic,* 27 November 1989, 28.

[39] Brown, "Fighting the Drug War in the Skies Over Peru."

[40] Trujillo, "Corruption and Cocaine in Peru."

[41] P. Murphy and T. Plate, "Commissioner: A View From the Top of the American Law Enforcement" (1977), 245.

[42] *The Los Angeles Times,* 24 October 1989.

[43] Peter Reuter, *On the Consequences of Toughness,* RAND Note 3347 (Santa Monica, Calif.: Drug Policy Research Center, 1991), 147.

[44] At year end 1988, the number of prisoners under the jurisdiction of federal or state correctional authorities reached 627,402, compared to 329,821 in 1980. This amounts to an increase of approximately 90 percent in eight years. Bureau of Justice Statistics, US Department of Justice, Bulletin, Prisoners in 1988 (1989).

[45] Bureau of Justice Statistics, US Department of Justice, Sourcebook of Criminal Justice Statistics—1988 612 (Table 6.31) (1988).

[46] See Messinger, Berecochea, Berk, and Rauma, "Parolees Returned to Prison and the California Prison Population" 13 (Table 5) (California Bureau of Criminal

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Statistics and Special Services Collaborative Report, 1988). In 1988, about 43 percent of the admissions to California state prisons were parole violators returned to prison by the Parole Board without a conviction for a new charge. Sourcebook 612, 11 (Table 3).

[47] Messinger, et al., 5.

[48] *San Francisco Chronicle,* 18 May 1989.

[49] *Strategy,* 26.

[50] Ibid.

[51] Ibid.

[52] *The New York Times,* 18 April 1989. Mr. Bennett has attributed the halting progress of the war on drugs to state officials who are reluctant to use state funding for new prison construction. *The Wall Street Journal,* 30 November 1989.

[53] *Social Structure,* 13.

[54] Ibid.

[55] *The New York Times,* 30 December 1989, 1.

[56] See Covino, *How the 69th Mob Maximized Earnings in East Oakland* (California: November 1985), 83.

[57] Center for the Study of Law and Society, *Courts, Probation, and Street Drug Crime: Executive Summary and Conclusions,* (Final report on the Targeting Urban Crime Narcotics Task Force, 1988), 4–5, 9. [hereinafter *Executive Summary].*

[58] Peter Reuter, "The D. C. Crime Surge: An Economist Looks at the Carnage," *The Washington Post,* 26 March 1989.

[59] Ibid.

[60] Ibid.

[61] Lawrence I. Golbe and Michael D. Merkin, "Cerebral Infraction in a User of Free-Base ("Crack"), *Nuerology* 36 (1986): 1602.

[62] John Kaplan, "Taking Drugs Seriously," *The Public Interest* 42 (Summer 1988).

[63] Terry Williams, *The Cocaine Kids: The Inside Story of a Teenage Drug Ring* (Reading, Mass.: Addison-Wesley, 1989).

[64] Phillipe Bourgeois, "Just Another Night on Crack Street," *The New York Times Magazine,* 12 November 1989, 63.

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Among the programs, a few stand out as worth expanding: education and training in moderation and self-command, short-term interventions to funnel problem drug users into long-term group self-help efforts, helping and forcing user/offenders to quit, and breaking up flagrant drug markets with as few arrests and trials as possible. Programs, like laws, should be judged by their results, not by the warm feelings they give those who design them and carry them out.

If we treat drug policy as a social problem to wrestle with seriously rather than as the occasion for a cultural holy war, we can reduce the damage done by drugs and by drug control efforts. The politics of the crusade against the currently illicit drugs often clashes with the practicalities of drug abuse control. Creating a measured fear of drugs—leading people to understand that drug use is risky and encouraging them to disdain a life spent under the influence—is an important technique of drug-control policy. But intolerance is always a danger in a puritanical republic, and the logic of "us against them" forces us to ignore the most widespread problems. Many of the loudest advocates of a war on drug sellers and users exclude alcohol and tobacco from their account, despite the enormous health cost of tobacco and the widespread crime and disorder associated with drunkenness.

Mark A.R. Kleiman
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*Thomas Szasz*

# The Fatal Temptation: Drug Prohibition and the Fear of Autonomy

IN AMERICA, QUIPPED WILL ROGERS, "Everything has a slogan, and, of all the bunk in America, the slogan is the champ... Congress even has slogans: 'Why sleep at home, when you can sleep in Congress?'; 'Be a politician—no training necessary!' "[1]

I would add that, of all the bunk in America, our champion slogans are about drugs and medical ethics: "Just say 'no' to drugs," "the sanctity of life," "pro-choice," "the right to life," "the right to die," "the right to treatment," "the right to reject treatment"—slogans all, some contradicting others and yet all coexisting comfortably in mindless harmony. If the right to autonomy—to our bodies, minds, and selves—means anything, it means a right to suicide. And if pro-choice means anything, it must mean the right to use or abstain from using any particular drug. And yet these are precisely the rights no normal American endorses. Indeed, we are so phobic about suicide that we fear even knowing about it. According to a survey reported in the May 18, 1992 issue of *U.S. News & World Report,* 71 percent of Americans would like libraries to ban "books describing how to commit suicide."[2] I suggest, then, that fear of the temptation to commit suicide is a critical, yet rarely considered, facet of drug controls.

The right to do X does not mean that doing X is morally meritorious. We have a right to divorce our spouse, vote for a politician we know nothing about, eat until we are obese, or squander our money on lottery tickets. Thus, the phrase *right to suicide* does not mean that suicide is a morally desirable or merito-

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rious act. It means only that agents of the state have no right or power to interfere, by prohibitions or punishments, with a person's decision to kill himself. Those who desire to prevent a particular person from committing suicide must content themselves with their power, such as it might be, to persuade him to change his mind.

Because we have a free market in food, we can buy all the bacon, eggs, and ice cream we want and can afford. If we had a free market in drugs, we could similarly buy all the barbiturates, chloral hydrate, and morphine we want and could afford. We would then be free to die—easily, comfortably, and surely—without any need for recourse to "death doctors" or violent means of suicide, and without fear of being kept alive against our will to die a protracted, painful, and extravagantly expensive death in a building misnamed a "hospital." We would then no longer have to complain about doctors, nurses, relatives, hospitals, and courts overtreating us, undertreating us, withholding pain medications from us, keeping us alive, and depriving us of our "right to die."[3]

How did the idea of a *right to die* arise? How can the inevitable biological destiny of all living beings be a right? What does the phrase mean? Actually, the phrase refers primarily to our confused rejection of the spectacle of doctors keeping moribund persons alive with the aid of modern biotechnological machinery. Why do physicians do this? Because they enjoy the powers science and the state have put in their hands; because they often have both professional and economic incentives for it; because they assume that is what the patient would want; because courts or kin command them to do "everything possible" to keep the patient alive; and, lastly, because withholding life-sustaining measures could be regarded as deliberately killing the patient. In short, we prattle about a *right to die* because we prefer mouthing uplifting slogans to thinking seriously about the meaning of life.

For most of us today, the term *sanctity of life* has lost virtually all meaning. We cling to life—up to a point. After that, we want to be "allowed" to die—an imagery that falsely implies that we are inescapably bound to persons determined to prevent us from dying. To deny them that role, we have complemented the proposition that we have a right to life (which has become the code phrase of the antiabortion movement), with the seemingly contrary proposition that we have a right to die.

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However, the similarity between these two semantically reciprocal rights is illusory. Each addresses a completely different set of existential choices and ethical perplexities. The phrase *right to life* refers to the ("natural") inception of life; moreover, this "right" is ascribed to *all* unborn fetuses and belongs to each unconditionally. Whereas the phrase *right to die* refers to the ("unnatural") termination of life; and this "right" is ascribed *only* to terminally ill persons and, in practice, often belongs to their relatives.[4]

Thus, the phrase *right to die* is emblematic not only of our skittishness about suicide and our longing for good doctors to kill us at just the right time and in just the right way, but, more fundamentally, of our repudiation of bodily self-ownership and the responsibilities that go with it. It remains to be seen how many Americans prefer legalizing doctors to kill them to legalizing themselves to own drugs, and shouldering the responsibilities which the ownership of such a valuable property entails.

So long as the phrase *right to die* does not include an unqualified right to suicide—a subject its supporters never mention—it is destined to be nothing more or less than just another step in the medicalization of life and in our headlong rush into the deadly embrace of the Therapeutic State. On the other hand, if the phrase is intended to encompass the right to suicide, then—lest it be an empty slogan—the right to die must include the right to drugs. We know, however, that most people—especially in the United States—consider the desire to commit suicide, much less the act itself, not a right but a symptom of preventable and treatable mental illness. As against this view, I hold that the option to commit suicide is inherent in the human condition; that committing suicide ought to be considered a basic human right and may sometimes be a moral duty; and the expectation or threat of suicide never justifies the coercive control of the (allegedly) suicidal person. At the same time, I consider it a basic moral wrong for a physician to kill a patient, or anyone else, and call it "euthanasia."[5] This does not mean that "pulling the plug" on a dying patient is (necessarily) an immoral act; it means only that doing so does not (necessarily) require medical expertise, should not be defined as a medical intervention, and should not be delegated (specifically) to physicians. I maintain that our longing for doctors to give us lethal drugs betokens our desire to evade responsibility for giving such drugs to ourselves; and that so long as we are more

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interested in investing doctors with the right to kill than in reclaiming our own right to drugs, our discourse about rights and drugs is destined to remain empty, meaningless chatter.

Of course, people cannot expect to regain their right to acts and objects unless they are willing and prepared to assume responsibility for the conduct of the acts and the care of the objects in question. Since the most important practical consequence of our loss of the right to bodily self-ownership is the denial of legally unrestricted access to drugs, the most important symbol of the right to our bodies now resides in our reasserting our right to drugs—to all drugs, not just to one or another so-called recreational drug. At this point, we come face-to-face with our real drug problem—namely, that most Americans today do not want to have legally unrestricted access to drugs. On the contrary, they dread the idea and the prospect it portends.

In sum, it seems to me that we have launched ourselves on a self-contradictory quest—that is, for an America where no one "abuses" drugs because doctors effectively control drug use, and where everyone dies a painless and pleasant death because doctors compassionately kill "dying" people who want to be killed. Having combined a dread of dying a protracted, pointless, and perhaps painful death with a fear of living with a free market in drugs, we have negated our chances for attaining pharmacological autonomy—that is, freedom and responsibility vis-à-vis the drugs we take similar to the freedom and responsibility we have vis-à-vis the foods we eat, the books we read, and the religions we profess.

ENDNOTES

[1]W. Rogers, "Slogans, Slogans Everywhere (1925)," in Bryan B. and Frances N. Sterling, eds., *A Will Rogers Treasury* (New York: Bonanza Books, 1982), 71.

[2]"Banishing books?" *U.S. News & World Report,* 18 May 1992, 76.

[3]See, for example, J. Somerville, "Illinois task force issues model right-to-die bill," *American Medical News,* 20 April 1990, 20.

[4]See T.S. Szasz, *Living With It* (Buffalo: Prometheus Books, 1991), 204.

[5]See T.S. Szasz, "The ethics of suicide (1971)," in *The Theology of Medicine* (Syracuse: Syracuse University Press, 1988), 68–85; "The case against suicide prevention," *American Psychologist* 41 (July 1986): 806–12; and *The Untamed Tongue: A Dissenting Dictionary* (LaSalle, Ill.: Open Court, 1990), 245–52.

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*David C. Lewis*

# Medical and Health Perspectives on a Failing US Drug Policy

THE US GOVERNMENT'S "WAR ON DRUGS" has become a war on drug users—a public moral crusade and law enforcement extravaganza that cordons off a rigid public policy from badly needed ideas and insights of medical and public health professionals who have spent a lifetime studying addiction, its causes and consequences.

On the national policy level, we need an immediate cease-fire in this war on drugs as presently battled—and a practical, fact-finding, more informed session at the negotiating table to prevent pockets of our society from crumbling or exploding.

Part of the problem with the war on drugs is the punitive social atmosphere created by the law enforcement process that has criminalized drug use—with an increasingly harsh, get-tough policy but with little actual success.

This commentary on our nation's drug policy takes particular note of the deleterious juxtaposition of medicine and law enforcement, and then presents a more realistic and humane concept of drug policy development.

Public health professionals have been far more active than their medical colleagues in fashioning alternatives to our current drug policy. Practitioners and leaders in both fields now must engage in a new dialogue with other disciplines to bring about gradual decriminalization in the nation's approach to drugs—a change essential to

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achieving effective medical and public health policies in the future. As a physician I look at illegal drug use[1] and drug control from a twin perspective: medicine, with its concern for patient care, and public health, with its focus on populations.

A major problem stemming from our drug policy is the negative effect it has on the quality of medical care offered to the addicted and the nonaddicted alike. Good medical care for illegal drug users and addicts is virtually unobtainable in our war on drugs culture. Care for the addicted is either inadequate or inappropriate in primary care settings, emergency rooms, and methadone maintenance programs. Pregnant cocaine users, in particular, suffer from poor treatment and public blame.

Patients who have never used illegal drugs also suffer from the influence of drug criminalization on medical practice. They are routinely denied adequate medication for pain from surgical procedures, cancer, AIDS, and other diseases—usually because physicians fear they could become addicts. Drug prohibition has led to a rejection of the medicinal use of marijuana, in spite of physician support for it. In addition, drug related street violence is more connected to drug criminalization than to the pharmacological effects of the drugs themselves.

To say that our policies need rethinking is not to minimize the tragic consequences of harmful drug use. I know from experience how much harm drug intoxication and dependence can do to individuals, families, and society. I have seen the suffering first-hand, and it disturbs me when suffering and cost are disregarded or minimized for the sake of making drug law reform arguments. Yet, much of our reaction to drugs is a media-and-politics distortion of their true impact. In important ways, our drug policy is irrational and symbolic of other social issues.[2]

Fashioning a new drug policy is complicated and difficult. Attempts to control recreational drug use and intoxication by law have not met with much success. All drugs can be dangerous; the surest, simplest way to avoid the danger is never to take any drug. This simple "just say no" solution is an unworkable one. Socially acceptable intoxicant use has been a reality for thousands of years

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in a variety of cultures. Clearly, drug use is no passing fad, and any policy designed to control drugs must face that fact.

## GETTING STARTED: THE ELUSIVE MARIJUANA "ADDICT"

Starting with an event that brought me into this field, I have observed the medical profession's reaction to drugs classified as illegal for over thirty-two years. In 1960, I was a junior medical student working on the psychiatry rotation in the emergency room of the Massachusetts General Hospital. A teenage boy was brought in from Beacon Hill by two friends with a complaint that he had "smoked too much marijuana." The triage house officer in the emergency room put him in the padded room which was reserved for violent patients and alcoholics. He assigned me to the case, and then called the police to find out what liabilities the hospital risked in treating narcotic addicts, since marijuana was then classified as a narcotic. At the same time, he reported the patient's name and address to state authorities in compliance with the law indicated by the sign "Addicts Shall be Reported"[3] posted in every emergency room in Massachusetts.

The nursing staff and attendants fussed over whether or not to restrain the patient. The boy was wide awake and talkative, maybe a little spacey, but he seemed to present no major behavioral problem. By the time I arrived in the padded room to examine him, he was gone. His friends, sensing danger, had sneaked him out.

The whole event was inconsequential, yet disruptive. I was reprimanded for letting the patient get away by the senior resident in psychiatry, who feared some unnamed legal difficulty because the patient was a marijuana "addict." An administrator demanded a full report.

This episode was in sharp contrast to the way the same staff handled a terrible tragedy earlier that week in which a MTA commuter train fell off the elevated tracks at the nearby Charles Street station. The emergency room was filled with the victims, and the speed, competence, and self-confidence with which that situation was handled was a model for emergency care. I was amazed that the nonexamination of a patient for marijuana intoxication in some ways caused more anxiety and raised more issues to be resolved in

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that hospital than did the MTA disaster, and I felt that any institution that could handle a major accident should be able to handle one teenage marijuana user.

## UNDERSTANDING DRUG ADDICTION

Later, as a senior medical student, I tried to learn more about marijuana intoxication but found little written on the subject. As to the phenomenon of neurotic organizational responses, I found nothing. But I stayed with the inquiry, wrote a paper on the history of narcotic addiction and then began a study of addicts in Boston's teaching hospitals. My interest grew from a need to explain why people with drug problems received so little quality care, even though their needs were similar to those of other patients. If I—an interested physician—had a knowledge gap, what about the rest of the profession?

In 1964 the *New England Journal of Medicine* published a two-part series that I coauthored with Dr. Norman E. Zinberg. One part was the history paper referred to above;[4] the other was entitled "Narcotic Usage: A Spectrum of a Difficult Medical Problem,"[5] our study of the medical care received by 200 drug addicts. This study revealed irrational care and even gross negligence on the part of medical practitioners. I was baffled and upset that these patients received such poor care. Norman Zinberg, a master at communicating the insights of his field to nonpsychiatrists, took a more conciliatory approach. We could not say that the patients were the difficulty but neither could we be too critical of the medical profession. After all, virtually no one in 1960 had received any formal education in medical school or anywhere else about caring for addicts. Our conclusion highlighted the crying need for physician education: "Medical training and research have not dealt with the problem adequately, and physicians are caught between legal complications and inadequate knowledge."[6]

We received about 1,000 requests for reprints, more than for any other paper either one of us has ever published. This startling reader response was instructive and decisive for me. It was then that I became committed to what has occupied a major portion of my professional life: improving medical education and caring for the addicted. Years later, I know that while we can and do effectively

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educate physicians, difficulties persist in caring for addicts, particularly those using illegal drugs. The moral crusade against illegal drugs that influenced the expectations of doctors and patients in 1960 is with us still. Surprisingly little has changed for the illegal drug user in the past thirty-two years.

## DRAWING THE LINE BETWEEN MEDICINE AND LAW ENFORCEMENT

The dysfunctional influence between medicine and criminalization that I experienced at the Massachusetts General Hospital continued during my stint as Chief of Medicine at the Washingtonian Center for Addictions in Boston. Founded in 1857 as an outgrowth of the Washingtonian temperance movement, the Center had a distinguished record of treatment and training programs. On my first day at work with hard-core (heroin, barbiturate, cocaine) drug addicts, I was compelled to give a stern lecture to the patients on the third floor about not smuggling drugs into the Center. After all, this was a treatment program not a prison. Patients were there voluntarily for help in staying away from drugs, not to consume their energies in arranging for drug drops.

They seemed to listen intently to their new medical director. My message was clear and resounding: no drugs! I reinforced that message by handing out a policy memorandum entitled "Drug Use On the Premises." I returned to my first floor office in time to see the memoranda fluttering down to the lawn of the hospital. Hastening back to the third floor, I delivered an impassioned speech about the need for us to fight addictions, not to fight among ourselves. My pride was hurt. But the issue had little to do with my pride or foolishness in believing that I would win an authority struggle with the patients. The issue was trust. The patients badly needed a therapeutic relationship with the staff and with the Center.

Providing clinically rigorous treatment for these patients required a structured, predictable environment to maximize their recovery. This meant tough, often arbitrary rules. The contrast between what we were doing and the rigors of street survival became more apparent when we delivered a consistent therapeutic message that they were not victims—not weak, helpless castaways—but people who could care for themselves, addicts who could take responsibility for and

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achieve freedom from their addiction. We developed the "special place" concept, a safe haven with rules distinct from the hunted/hunter mentality of the street. Many succeeded in this clinical atmosphere, but we constantly struggled to maintain trust and provide a positive clinical milieu. While at first the patients were inspired to think beyond their street-life stereotype as losers, eventually societal negativity toward addicts undermined the expectations of successful treatment for both patients and physicians.

Bureaucratic events beyond our control seriously undermined our efforts. For example, during a routine program audit at a nearby Lowell, Massachusetts methadone maintenance program, the FDA removed patient records.[7] As soon as word got around, patients feared contact with treatment programs, thinking that their treatment records would be read and used for law enforcement purposes. State police routinely filmed our patients from a disguised bread truck. Not that our patients' problems or our treatment success were determined only by outside influence; many had severe psychological problems and long-standing delinquency, and all were seriously addicted. But the criminalized atmosphere of fear, suspicion, and punitive menace badly hindered our patients' ability to trust and participate in treatment. Did we really succeed in making the Washingtonian Center for Addictions a special place where street addicts could receive quality care? Probably not. With few exceptions, I never experienced the level of trust between patient and physician there that I associate with quality medical care.

## "ADDICTS SHALL BE REPORTED"

The failure of primary and emergency medical care for the illegal drug user was an important force behind the development of the national free clinic movement of 1967–1972. In Cambridge and in Boston, the medical community mobilized in a major voluntary effort to provide medical care and counseling for youth using illegal drugs. I served as medical director of the Beacon Hill Free Clinic. In five years, we saw about 10,000 patients. Although some were heavy users of illegal drugs, their medical problems rarely related simply to drug use. Most had infectious diseases that required immediate treatment, but they were reluctant and afraid to go to one of Boston's many fine teaching hospitals where some had been hassled and misunderstood. They chose the free clinic in spite of our urging that

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they make use of the existing medical system. Our volunteer physicians, who were frequently the same physicians these patients could have seen in the teaching hospitals of Harvard, Boston University or Tufts, never disputed that this youthful population received poor care at their hospitals.

One barrier to treatment access, already mentioned, was the "Addicts Shall Be Reported" requirement. I have seen adolescents enter the emergency room, read the sign, turn on their heels and run. Physicians were required to report opiate, cocaine, and marijuana "addicts" through a telephone number assumed to be police-connected, although the calls actually went to the Food and Drug Division of the Public Health Department. As it turned out, no one ever used these reports; they were just filed. The major effect of the statute, originally designed to provide public health surveillance of addicts, was to erect a barrier to needed health care. Once medical professionals understood this and testified about the detrimental effect of the reporting statute, both the Massachusetts Department of Public Health and the Attorney General supported the successful effort to repeal the reporting law.

## MIXED MESSAGES

The struggle to maintain therapeutically necessary dignity for the addict is constantly undermined by sensational media coverage, befitting a war on drugs syndrome that first demonizes drugs, then the drug users. Such a complicated and serious issue can neither be worked through in soundbites over television, nor in bizarre newspaper columns like a recent effort in the *New York Times* by A. M. Rosenthal, entitled "Politicians of Silence."[8] The column not only pointed out how little drug issues had entered into the 1992 presidential campaign but also presented Rosenthal's overwrought views on the drug problem:

> So politicians assume, doubtless correctly, . . . that Americans are too stupid to understand that one day some addict from a mean street somewhere might wander into their neighborhood and teach them a civics lesson by sticking a knife in their ribs . . . But about 6.5 million drug abusers so abuse themselves that they cannot function in or for the American community. They fill jails, clog hospitals with needle-AIDS and TB, crowd shelters, and provide morgues with a steady dependable supply of the corpses of their victims.

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However well-intended, the column reads like a page out of former Narcotics Commissioner Harry Anslinger's biographical book, *The Murderers*[9] or the scripts from the 1930s movies *Reefer Madness* and *Cocaine Fiends*. While promoting therapeutic community treatment and the Partnership for a Drug-Free America Campaign, Rosenthal's sensational description of "drug abusers" and their problems outweighs the positive value of promoting prevention and treatment. Such rhetoric is both harmful to the truth and to the provision of medical care for the addict. Most people who use illegal drugs bear no resemblance to the dramatic stereotype of the drug-crazed addict, but the inflammatory and demeaning rhetoric keeps appearing.

## PATIENTS GET SHORT SHRIFT ON METHADONE MAINTENANCE

A classic example of compromised care is methadone maintenance treatment for heroin addicts. Though methadone maintenance is the only treatment for heroin addicts attracting large numbers of patients over a significant duration, the history of this form of treatment has been dogged by controversy and underfunding. Public and professional ambivalence toward methadone maintenance has resulted in patients routinely receiving methadone doses known to be inadequate. Further, arbitrary limits on treatment duration have led to premature detoxification from methadone and a return to heroin.

Methadone is a synthetic opioid. Sufficient oral doses blunt the effects of injected heroin, reducing the heroin high and the addict's heroin-seeking behavior. Thus, patients on methadone can more easily eliminate their use of heroin, reduce their criminal activity, increase their productivity and decrease the needle spread of HIV infection. Despite these positive features, a steady onslaught has occurred against methadone maintenance.

Attacks against the medical model of treatment are not new. Starting with the 1906 Pure Food and Drug Act and the 1914 Harrison Narcotic Act, a succession of federal regulations have hampered drug therapy of addicts. Over the years federal regulations have steadily encroached on medical autonomy and eroded clinical judgment.

Until 1964 abstinence-oriented therapeutic communities and rehabilitation hospitals were the only treatment alternatives for heroin addiction. They provided effective intervention to a limited number

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of patients. Then, methadone maintenance, developed at Rockefeller University by Vincent Dole and Marie Nyswander, became available.[10] At first, a clash of the treatment philosophies raged between the therapeutic communities who advocated complete drug abstinence and the newly emerging methadone treatment programs. Many drug-free recovering addicts saw methadone maintenance as a substitution of one addiction for another.[11] Nonetheless, many methadone patients succeeded in reordering their personal and social lives, gaining distance from the street culture. They were treated by private physicians as well as in hospital settings.

New regulations in the 1970s effectively eliminated the ability of the private medical practitioner to prescribe methadone for heroin addicts or, for that matter, for any other patient. Methadone was removed from pharmacies so that physicians could no longer prescribe methadone for pain control. Further, all methadone for maintenance treatment had to be dispensed in designated and highly regulated programs. Patients became "clients" and treatment opportunities became "slots" funded at a specified amount each year.

During the late 1970s and early 1980s, as the "debate" heated up, many physicians lost interest in methadone treatment; the pool of people with experience and expertise in the field shrank. Simultaneously, methadone policy shifted from maintenance to "limited" maintenance. Rather than being maintained on methadone indefinitely, patients had to be detoxified from it within a specified time. The time was often chosen to fit the budget and waiting list, not the needs of the patients. With this trend toward shorter treatment came lowered methadone doses. These doses failed to compete successfully with the heroin high, the rationale for using methadone in the first place. This situation persists today; a recent study of 82 percent of US methadone maintenance programs shows that over a third were using doses inadequate to compete with heroin.[12]

The AIDS epidemic has forced renewed interest in methadone maintenance treatment, since the treatment reduces use of injectable heroin and thus the risk of HIV transmission by shared-needle use among addicts. Now, because of the urgency of reducing needle use, there are cooperative programs between methadone treatment programs and therapeutic communities. Yet, the treatment is still underutilized given its effectiveness, and programs are available only in Holland and Hong Kong to all who are in need. The legacy of two

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decades of ambivalence and compromised medical treatment now includes ineffectively low methadone doses, premature detoxification, and over-regulation by the federal government.[13]

## A PRESCRIPTION FOR PAIN

Street addicts are not the only ones who receive second-rate care because of misunderstanding and fear of drugs. Needless pain is experienced by thousands of medical and surgical patients every day in this country, because their physicians avoid using the strongest and most effective pain killers. This undermedication stems from physicians' fears that their patients will become addicts to strong pain killers and that they will be liable if their patients became addicted.[14]

Opioids, including morphine, dilaudid and heroin (outlawed for use in medical practice in 1924), are the strongest pain killers. Physicians have gone from Dr. Thomas Sydenham's praise of opium in 1848 as "God's gift" to medicine to regarding opium and its derivatives as potential troublemakers for their medical practices. A new medical term, "opiophobia," is now applied to the irrational underutilization of these drugs.[15] This routine underdosing of patients in pain is remarkably inconsistent with medicine's longstanding mission to relieve pain and suffering.

Contrary to the fears of physicians and patients alike, pain killing opioids are not usually addicting in the context of medical practice. The fears come from two basic misunderstandings. The first is that "tolerance"—the need to increase dose to achieve the same pain relief is synonymous with "addiction." But tolerance is not addiction. Addiction is a chronic relapsing illness seen in only a small minority of those who experience tolerance. The second misunderstanding is that drugs cause addiction. Drugs do not cause addiction. The effects of drugs, including addiction to drugs, are best understood by the mutual interaction of three elements: the drug, the person, and the social setting and culture in which the drug is taken.[16]

While the drug, the first of these three elements, may be the same "on the street" as in the doctor's office, the other two elements are definitely not in most cases.[17] In the medical situation, the person is a patient, the setting is a hospital or doctor's office, and the culture expects physicians to relieve pain in the safest and most effective manner. Thus, the critical elements of the configuration of drug, person, and social setting which foster addiction are not present.

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These messages—that tolerance is not addiction and that drugs per se do not cause addiction are basic to any good medical school pharmacology course. They are also a lesson to be learned by the media and many politicians.

The premier medical pharmacology textbook conveys this poignant message to physicians: "No patient should ever wish for death because of his physician's reluctance to use adequate amounts of effective opioids."[18] Its author is no wide-eyed radical in the drug field. Dr. Jerome Jaffe, a distinguished clinical pharmacologist and psychiatrist and former head of the White House Special Action Office for Drug Abuse Prevention, the command headquarters for the Nixon war on drugs, knows of what he writes. In a recent comprehensive review of the treatment of cancer pain, Jaffe presented two moving clinical vignettes of elderly patients—his own father and father-in-law, who suffered pain needlessly while they were dying. Says Jaffe: "How can it be, that after twenty-five years, we have made such little progress in teaching medical students and our colleagues about the management of pain?"[19]

Government is taking steps to address pain control issues. On March 5, 1992, the Department of Health and Human Services (HHS) Secretary Louis Sullivan released the report of the Task Force on Pain, the first in a series of medical practice guidelines issued by HHS.[20] This report confirmed the general underprescribing of pain medication, finding that about half of all surgical patients suffer unnecessarily from pain. The report further cites the low risk (about 1 in 2,500) of becoming addicted following a hospital stay where surgery is performed. The panel concluded that it is a myth that analgesics, including the strongest ones, the opioids, are commonly addicting when used in medical practice for the treatment of pain.

Unfortunately, physician concerns about legal ramifications remain a major barrier to rational prescribing. I fear that the ongoing dichotomy between illicit and licit drug use will continue to influence physician practice, and that an unwanted but inevitable side effect of drug criminalization is that some cancer, AIDS, and surgical patients will continue to suffer pain needlessly.

### Rx: MARIJUANA

Should physicians be permitted to prescribe marijuana to alleviate suffering?[21] The Administration and Congress say no. For example,

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a handful of patients, thirteen to be exact, had been granted the use of marijuana, supplied by the federal government through their physicians. In March 1992, the Department of Health and Human Services decided to stop granting new permissions for such usage. Why is the medical use of this drug so feared and restricted?

Marijuana has been used as medication in Europe and America since the nineteenth century. There is no doubt that it is an effective treatment for relieving symptoms of severe muscle spasm, increased intraocular pressure of glaucoma, and severe nausea which accompanies chemotherapy and radiotherapy.[22] Those who oppose medicinal marijuana use claim that other medications currently available, including Marinol, are effective enough. Marinol is an oral pharmaceutical preparation of tetrahydrocannabinol (THC), one of the active ingredients of marijuana.

Marijuana's illegal status clearly damages its respectability as a medical drug. In the most recent round of government decision-making about marijuana's medical use, Robert C. Bonner, the chief of the Drug Enforcement Agency (DEA) of the Justice Department, contravening an earlier judicial decision,[23] rejected a proposal to allow doctors to prescribe marijuana legally because he concluded it was not medically effective. No wonder that there are ambiguities about the boundaries between medicine and the law when an enforcement official makes medical policy.

A recent survey of cancer specialists indicates that they disagree with DEA policy. Of the over 1,000 survey respondents, 44 percent reported that they had recommended marijuana to a patient undergoing chemotherapy. 77 percent of those who said they had enough information to compare the efficacy of marijuana with Marinol stated they believed marijuana to be equally or more effective, and nearly half the respondents said they would prescribe marijuana if it were legal.[24] It is a sad distortion of the doctor-patient relationship when a doctor believes that marijuana is the best treatment for the patient's condition yet is prohibited from advising its use because the physician fears implicit collusion with the patient to break the law.

The recent case of Kenneth and Barbara Jenks of Florida illustrates the human cost of the turf war between medicine and the law over marijuana.[25] Both Jenkses used marijuana to counter the debilitating nausea and weight loss that accompany HIV infection which Mr.

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Jenks, a hemophiliac, contracted through a blood transfusion and subsequently transmitted to his wife. Arrested at their home for growing two marijuana plants, the Jenks's defense of medical necessity was rejected; they were convicted of a felony for cultivation of marijuana. The Florida State Court of Appeals reversed their conviction, so the Jenkses now obtain the drug legally from the government. Their problem did not change, but they went from being "substance abusers" to "patients."

The real issue is not whether marijuana is the best pharmacological drug available for its proven effective uses, but why medical use should be so restricted and feared. There is great concern in Congress and the Administration that making marijuana medically available conveys the wrong message. This is a recurring theme in the making of drug policy. Needle exchange was recently trounced by the Administration because it, too, conveyed the wrong message; this, despite a strong contrary recommendation of the National AIDS Commission.

I believe that approving marijuana's medical use would convey the right message, a message of compassion which acknowledges that the government understands that it is not the drug itself which causes problems. It is the way the drug is used, the motivation of the user, and the circumstances of its use that determine harm or benefit. My only reservation about the importance of the medicinal use of marijuana is that it has become the major focus of medical input in some policy reform discussions, as if this were the only topic around which medicine should interact with drug policy reform. The medical profession's policy priorities should be to address the negative ways in which current drug policy affects care for thousands of illegal drug users and addicts and the way in which our fears about illegal drugs influence physician prescribing of now available controlled substances. With its importance inflated, the medical marijuana issue resembles one symbolic crusade fighting another.

## DRUG VIOLENCE SWAMPS EMERGENCY MEDICINE

The battle casualties of the war on drugs are evident in every urban emergency room, where physicians see about four times as many victims of violence as do the police.[26] Visiting a busy hospital emergency room these days is a traumatic experience. To spend a day

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in such a setting is to be horrified by the senseless carnage. "Violence is as much a public health issue for me and my successors in this country as smallpox, tuberculosis, and syphilis were for my predecessors in the last two centuries," declared former Surgeon General C. Everett Koop, M.D. in 1984.[27] To design effective interventions we need to understand the precursors to violence both in children and adults, the genesis and effects of violence among family members, and the nature of street violence. Efforts such as a large prospective longitudinal study of several thousand children at risk for antisocial behavior are already underway.[28]

The public perception that drugs "cause" violent crime, particularly predatory street crime, is a prominent factor in shaping public policy. How accurate is this perception? Medically, there appears to be little direct causation between drug effects and violence. Research findings show consistently that the psychopharmacological influence of drugs themselves appears to be a minor factor in violence.

A study of crack violence among adolescents in Miami found that about 60 percent of the violence was related to crimes committed to secure money to buy drugs; only 5.4 percent was related to the psychopharmacologic effects of drugs.[29] A study of cocaine-related homicides in New York City showed that most violence was due to territorial disputes among drug dealers; about 2 percent could be ascribed to direct psychopharmacologic effects.[30] These studies and others confirm that most drug violence is an economic side effect of drug prohibition, not an effect of the drugs themselves. One important exception is alcohol for which there is strong data that intoxication directly influences violent behavior.[31]

Here we see an instructive Catch-22 situation. It appears that drug prohibition policies lead to violent crime and that greater drug prohibition leads to more violent crime. Yet, the supposed crack connection with street violence was a major factor, at least in political rhetoric, in determining President Reagan's 1984–1985 escalation policy in his war on drugs. My perception at the time was that the focus on crack cocaine was a deflection (a displacement in psychological terms) from certain basic underlying issues regarding crime. The political response then, a war on predatory street crime, was misnamed a war on drugs. Sadly, fundamental social and economic issues such as poverty and community and family disorganization,

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and at an individual level, today's antisocial behavior among young children and adolescents, were subordinated to fighting drugs. Not only did the drug focus fail to stem the street violence, but it diverted attention from the more difficult and costly political task of tackling the known causes of violence.

This administration wishes to keep the focus on drugs. To attack the underlying causes is a diversion from their war on drugs. On January 10, 1992, director of the Office of National Drug Control Policy, Robert Martinez, said that blaming drug problems on social causes "victimizes drug users and strips them of their freedom of choice."[32] This is doublespeak, rivalling George Orwell's best.

## COCAINE AND PREGNANCY

How does a policy that vilifies the illegal drug user translate into human cost? The drug news of 1990–1991 featured dramatic predictions that from 375,000 to 650,000 "cocaine-exposed babies" each year would suffer low birth weight, neurological impairment, and fetal malformations. The annual care cost for these babies was projected as high as three billion dollars. Dire predictions were also made about the effect of maternal cocaine use on childhood development. More than fifty mothers were prosecuted, but not one was convicted on charges including drug possession with intent to deliver, child abuse, and murder.

In the frenzy of accusations, serious questions were overlooked about the validity of the information that attracted national concern in the first place: the damaging effects of cocaine on the fetus. In fact, most of what is attributed to cocaine's effect on low birth weight is also associated with poverty, inadequate prenatal care, and poor nutrition. One leading investigator notes that while the neonatal toxicity of cocaine is of course important, these other factors may well play a more important role in the damage.[33] When cocaine-using mothers, even as late as the third trimester, receive treatment for their cocaine problem, along with good prenatal care and diet, their newborns have normal birth weights and, so far, no detectable neurological abnormalities.[34] Also, no scientific evidence yet supports the claim that cocaine causes adverse developmental outcomes in these children.[35] A major reevaluation is now underway in the

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scientific community concerning the degree of cocaine's role in causing fetal damage. Leading scientists recommend a "suspension of judgment about the developmental outcome of cocaine-exposed babies until solid scientific data are available."[36] What if cocaine does not cause the horrendous damage as portrayed? Are we going to charge women with the crime of poverty?

Closer examination reveals that not only were the potential harmful effects of cocaine magnified, but also the numbers of cocaine babies. As far as I can determine, the 375,000 cocaine-baby number originated in 1989 with one investigator's estimate of the number of pregnant women taking illegal drugs.[37] Also, in 1989, William Bennett, in a television interview referred to "200,000–300,000 crack-addicted babies" born annually.[38] Thereafter, press stories routinely cited 375,000 cocaine-babies costing three billion dollars annually. Despite all this news, neither the actual number of cocaine-babies nor the annual cost of meeting their needs is known. Have we again overportrayed the drug role in our zeal to do good?

As with so many other instances where drugs and drug users are blamed, the Secretary of Health and Human Services assailed drug use by pregnant women in a speech in Boston,[39] stating that these women were committing child abuse and that, in serious cases, mothers should lose parental rights. News stories attributing the most graphic examples of damaged neonates solely to drug use raised concern about these children being written off. To compound the negative stereotype, these greatest number of pregnant cocaine users are poor, inner-city mothers.

Medical ethicists struggle to balance privacy rights of these pregnant mothers with the needs of society to protect their children. Widespread mandatory treatment for drug use during pregnancy is under active consideration.[40] In addition, child protective laws are being modified; programs are being established with special live-in facilities for mother and child, or foster care for the children, with cocaine treatment elsewhere for the mothers.

The use of the criminal law to punish these women is widely condemned by medical professionals. The AMA has joined addiction medicine specialists in protesting this repressive and punitive approach, by pointing out that pregnant women need access to excellent prenatal care and addiction treatment, neither of which is available in many communities.[41]

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Blameful attacks on the mother, litigation to punish the mother, and reflex separation of mother and child because of maternal cocaine use is not justified by the medical data. The dichotomy between legal and medical treatment of these women is another example of medicine under the influence of drug criminalization.

## THE SCORECARD: SOME WINS, MORE LOSSES

Illegal drug use has diminished in middle-class populations. Since drug availability has changed little, it follows that public education or some other factor has affected user choice. While the Partnership for a Drug-Free America campaign and community-wide prevention programs are widely credited with this success, the downward trend, except for cocaine, started in 1978, predating these prevention efforts and the Reagan war on drugs. Yet, one can take encouragement from some aspects of the current prevention programs. Much antidrug prevention activity is now directed at improvements in the quality of community life, with citizens retaking control of the streets. These initiatives have led to the development of thousands of new community-based voluntary organizations.

But the harmful cocaine and heroin use has increased recently among inner-city minorities.[42] Violent crime is also on the rise. Decreasing drug production in other countries together with interdiction and local law enforcement have not had a profound effect on the availability or harmful use of illegal drugs in this country. As far as the differential effects of the war on drugs, it is no surprise that the enforcement approach worked better where affluent suburbanites had more to lose than poor inner-city residents. In 1973, New York State enacted the nation's toughest drug law and enforced it vigorously. A report on the results makes its failure clear: "The available data indicate that despite expenditure of substantial resources, neither of the objectives of the 1973 drug law was achieved. Neither heroin use nor drug-related crime declined in New York State."[43]

Treatment has done little to create a drug-free or addiction-free society; only a small percentage of illegal drug users enter treatment. While programs have expanded, treatment on demand is not available for all who seek it. For those in treatment, a two-tier system—one financed privately and the other publicly, with marked inequities in access and adequacy of care—hinders the effort.[44]

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Despite the popular moral crusade against illegal drugs, people now know that the drug policy is not achieving its aims. Clearly signaling that something is wrong are the calls for radical reform coming from across the political spectrum, from William F. Buckley, Jr., Milton Friedman, and George Schultz to Anthony Lewis and Kurt Schmoke. *TIME* magazine spelled it out: "A Losing Battle—Despite billions of dollars and more than a million arrests, the war on drugs has barely dented addiction or violent crime."[45]

## HEALTH POLICY AS ALTERNATIVE TO POLICE POLICY

A battle is developing between health and enforcement policy. Public health leadership has taken a stand against the enforcement-oriented war on drugs by recommending alternative policies which focus on harm reduction. On November 16, 1988, the Governing Council of the American Public Health Association (APHA) adopted the policy recommended by its Section on Alcohol and Drugs.[46] The policy statement criticized the misplaced priorities and strategies of the war on drugs, citing as its major flaws: the primary focus on illegal drugs; the disregard of environmental factors; the inadequacy and poor planning of official education programs and mass-media campaigns; the attention to specialized treatment and recovery needs; and insufficient funding for research and evaluation. APHA recommended high priorities for prevention, treatment, evaluation, and research, and emphasized the importance of using scientific bases for policy formation as exemplified by two recent Institute of Medicine studies.[47]

In January 1992, the Department of Community Services of the AFL-CIO invited interested groups to its Washington headquarters to discuss the war on drugs policy and alternatives to it. Even on short notice, the meeting attracted one of the largest representations of prevention and treatment interests that had ever come together. Over eighty national professional organizations sent representatives. Following the meeting, over fifty organizations, many not habitually associated with drug reform (American Hospital Association, AFSCME-AFL-CIO, APHA, American Nurses Association, American Academy of Family Physicians, and the March of Dimes) endorsed the release of a critique entitled "The 'war on drugs': Failure and Fantasy. What has the $35 Billion Investment Bought?"

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The statement declares the war on drugs a failure because drug use is portrayed as a moral failing rather than recognized as a public health problem. The document, critical of a national strategy which gives priority to interdiction and law enforcement, targets casual drug users rather than addicts, and virtually ignores alcohol, recommends that at least 50 percent of federal funds, rather than the current 25 percent, be allocated for prevention and treatment programs.[48]

## CLARIFYING THE PUBLIC HEALTH AGENDA

Proponents of a public health approach have a variety of plans. Some are primarily interested in decriminalizing illegal drugs, others in more stringent regulations on legal drugs, still others in a more rational classification of drug harm that will bring disease and health policy into congruence. So far the public health approach has had its greatest impact on legal drugs.[49] Public health and medicine are vanguard advocates of greater restrictions on legal drugs, prompted by medical and public health research about the dangers of smoking and drinking. Their platform is opposed by growers, manufacturers, suppliers, and users.

This new crusade, led both by professionals and the lay public, includes attacks on both suppliers and users. Smokers face new restrictions daily about where and when they may smoke. Tobacco advertising is under attack by citizens' lobbies, organized medicine, and the public health establishment. Similarly, beverage alcohol manufacturers are condemned for their advertising and promotional practices. While there is something to be said for these initiatives, the direction of this continuing trend could end with the inclusion of legal drugs, like nicotine and alcohol, in the illegal framework. How far will this go? Will a decriminalization of illegal drugs be balanced by a recriminalization of legal drugs?[50]

A clearer public health perspective[51] would probably diminish the symbolic nature of the drug crusade and consider all drug use in a more consistent, scientific, and rational way. On the other hand, public health will still carry out the social and moral mandate which, in the United States at least, is fixated on formal controls. This would put the public health establishment in a quasi-enforcement position—with some historical precedent. The images of quarantine in

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Camus' *The Plague* are vivid reminders of the oppressiveness of public health controls.

## COERCION AND CO-OPTION: MEDICAL PITFALLS

There are potential coercive excesses in the medical/public health approach to drug use and addiction that could be no less onerous and no more effective than the present imposition of criminal sanctions. Widespread drug testing and the intervention of employers against employee drug use are coercive measures, even if they are based on arguments from the fields of public health and medicine. Employers are becoming health police. One recent ad from the Partnership for a Drug-Free America campaign states "Help an addict. Threaten to fire him." Consumers have not been quiescent. Smokers have sought protection for themselves, and twenty states have now passed laws against using smoking outside work as the basis for denying employment.

One variation on the public health approach is the idea of medicalizing drug policy,[52] making medical care for addicts the focus of attention. What are the implications of medicalizing the illegal drug problem? Medically supervised care is a voluntary alliance between doctor and patient, and it is most effective under these circumstances. While coercive pressures at work, in the family, or among peers may encourage an addict to seek treatment, that treatment is still voluntary if the patient is free to leave without legal consequences. The fact is that only a small percentage of addicts to any substance, legal or illegal, ever seeks drug treatment. I believe that the medicalization of drug policy would bring about an unwelcome shift to the "aggressive use of civil commitment," a deleterious outcome. We cannot treat our way out of drug use or drug problems.

It has even been suggested that decriminalization would be legitimized if formerly illegal drugs were dispensed by physicians. This would put the physician in the role of distributor of drugs used for recreational purposes. Physicians could presumably withhold drugs from people who ought not to receive them. Since most nonmedical drug use is literally nonmedical, in the sense that there is no illness or disease, this would make physicians the arbiters of acceptable recreational use. The likely result would be for them

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to find pathology in recreational use, as they are trained to look for pathology. Alternatives to our drug policy should promote health, not fabricate disease.

Currently, the movement toward the decriminalization of illegal drugs is being led by social scientists and lawyers, including some from business. Meaningful dialogue can occur only if it attracts also the leadership in medicine and public health, as well as representatives of the criminal justice system. In my experience, proponents of the present war on drugs policy find open debate about alternatives impractical and potentially harmful, usually believing critics to be out of touch with the tragedies that drugs produce. Conversely, reformers tend to downplay the harmful effects of illegal drugs; some are antimedical, perceiving a high degree of physician complicity with drug criminalization policies.

The few physicians I know who have taken a position on one side or another of the decriminalization debate have either been ignored or vilified.[53] There is a virtual absence of medical and public heath professionals in the debate, and while the Drug Policy Foundation and the Criminal Justice Policy Foundation [54] provide opportunities for discussing drug policy reform, both public health and medicine are virtually absent from these settings.

What can medicine contribute to the dialogue? By tradition physicians will be attracted to an approach that heals while reducing harm. *Primum non nocere*[55]—first, do no harm—still serves medicine well, and can also inform drug policy. In that spirit, I offer the following preliminary thoughts on engaging fundamental principles of social and health policy in the dialogue.

## DEVELOPING A WORKABLE POLICY MODEL

Most of us are able to feel concern for the suffering of those with drug problems, but our capacity for empathy is limited by the negative social impact of the drug users' behavior. Hence, we feel a need for reassuring formal controls. The tension between caring and formal control is a central theme in establishing social policy. Likewise, harm reduction and safety are themes in the development of public health policy. In addition, the prominent role of social norms and peer influence on behavior should make it clear that

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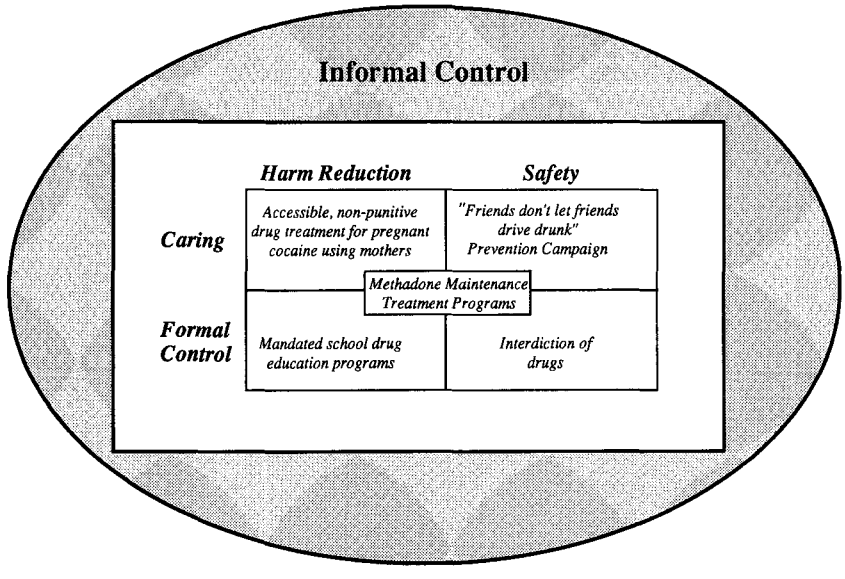
informal controls are a key force in any policy design. The goals of drug policy should be:

1) to reduce harm
2) to increase safety
3) to provide care for those who need it, and
4) to achieve a balance between formal and informal drug control by fostering the social atmosphere where informal controls are maximized to the limit of their effectiveness.




**Drug Policy Development Model**

**with examples of interventions**

**Harm Reduction** - Reducing the damage or the potential damage caused by drugs to current users, their families, and close associates
**Safety** - Reducing or preventing the negative impact of drug use on society
**Caring** - Using our capacity for empathy, caring, and helping those who suffer (e.g., the drug user, family, friends) from the effects of harmful drug use
**Formal Control** - Exerting controls such as laws and regulations
**Informal Control** - Fostering development of norms, expectations, social sanctions leading to the self-regulation of behaviors

The policy development figure pictures these goals with examples of interventions. Interventions will often involve interaction between two or more elements of the model. For example, the "friends don't let friends drive drunk" campaign shares elements of both caring and safety. "Interdiction of drugs" is formal control, administered by law

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enforcement, but it also encompasses safety because its main purpose is to ensure a society safe from dangerous drugs. "Methadone maintenance treatment programs" serve all the goals. Safety is provided for through both formal control (regulations for methadone dispensing) and caring (decreasing the spread of HIV infection). Likewise, harm reduction is achieved through formal control (regulations for minimum clinical staffing) and caring (helping the individual successfully overcome addiction).

Informal controls are visualized as enveloping the model matrix, because their influence is pervasive and affects the expression of every other element. The fact that informal control is a background influence is not to belie its importance. Informal control has been proposed as the most important force in determining socially sensible and nonproblematic drug use.[56] Generally speaking, if informal control fails, formal control replaces it, and the institution of such controls will often preclude the natural development of informal controls.[57]

At present, supply and demand reduction is the conceptual framework within which policy is expressed and its progress measured. Supply measures refer to production, interdiction, and the activities of local law enforcement. Demand refers to the influence of prevention and treatment. In my view, the simple supply/demand dichotomy is inadequate and misleading because important social and health parameters are not adequately addressed by that model.

The conceptual model presented here expands on supply and demand analysis. In the figure, most supply-side interventions fall at the intersection of formal controls and safety. Interventions based on the other elements and their interactions are more typically part of the demand side of drug policy. A conceptual framework for drug policy development should not only take these goal related elements into account but also define them in such a way that they become measurable objectives. For example, in order to analyze harm reduction, measurements of *harmful* use rather than all use will be required. The assessment of safety will necessitate the direct measuring of how the policy or intervention effects safety (or the lack of it). As discussed earlier, measures of the circumstances of violent acts need to be refined if we are to separate the influence of drug intoxication compared to drug dealing. Such a new look can be useful in stimulating new hypotheses for resolving drug policy issues which

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should encourage empirical testing to see what works best. Indices that portray the model elements and their interactions will require reformulation and analyses of existing data sets and/or the collection of new data. A study group of graduate students and faculty at Brown University is now working on the delineation of new hypotheses and measures.

## FINAL COMMENTS

Of the several comments I received from colleagues who reviewed this manuscript, one deserves special attention. The question concerned my assertion that little has changed in my thirty-two years in this field. The questioner asked about crack cocaine. "Didn't the crack cocaine epidemic change the medical view of excessive damage that illicit drugs do, and, at least in part justify the federal 'war on drugs' policy?" My answer was, "No," and I'd like to explain why. This is not to deny that the widespread and repeated use of crack cocaine has caused death and disability and that the life of a habitual crack user can be agonizing. To say anything else would be cruel to those who have suffered.

I believe the crack epidemic changed our view of addiction. The high relapse rate and remarkable degree of craving after sporadic use was different from the addiction relapse pattern seen after the chronic heavy use of other drugs. But some things remain the same. The current crack epidemic, the LSD epidemic of the late 1960s and early 1970s, and the PCP epidemic in the late 1970s and early 1980s all share the characteristic that most users did not and do not suffer medical harm. This is not to deny some of the horror stories about the effects of those drugs; but from reading the stories, including some overwrought medical commentaries, one would believe that LSD did nothing but cause "bad trips," psychosis and suicide, and that PCP caused nothing but violence and psychosis. For crack cocaine, the image is of frequent violent behavior and cardiac arrest. In contrast, the reality is that although cocaine use is risky, its extreme consequences are rare. From a medical and public health perspective, cocaine use is not the major public health problem portrayed in the newspapers. To put its harmful effects in the context of other drugs, no more than 10,000 deaths occur annually from all illegal drug use, while the toxicity and medical complications of

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alcoholism account for over 100,000 deaths annually and the medical complications of chronic cigarette smoking for 400,000.

The absence of medicine in our national drug policy debate is deplorable and should be corrected. Concerning alternatives to current practices, I agree with a policy of gradual decriminalization of drug use. We can no longer fight a losing battle to force criminal justice solutions for medical and social problems. I strongly support a shift toward prevention and treatment, for their own value and in order to start moving away from reliance on the criminal law. Such a shift, even an incremental one, will not be easy. Drug policymakers have long recognized that any diminished use of the criminal law, our most powerful symbol of safety, is difficult to achieve.[58] Nonetheless, the time has come to declare a cease-fire in the war on drugs.

In the thirty-two years that I have observed the adverse health effects of the skirmishes and wars against drugs, little has changed for the better. A more informed and open-minded dialogue on our national drug policy is called for.

ACKNOWLEDGMENTS

Several colleagues, coworkers, and students devoted time and energy to a critique of this manuscript on short notice. While some did not share my conclusions, they made detailed suggestions. Their response was greater than anticipated and bodes well for the wider policy dialogue that this paper proposes. I am very grateful to Carolyn Cannuscio, Patrick Clifford, Larry Culpepper, Marc Galanter, Fredrick Glaser, Lloyd Johnston, Eleanor Lewis, Steven Lewis, Stephen Oberbeck, Rochelle Rosen, Sidney Schnoll, Barry Stimmel, and Andrew Weil for their reactions and for making the essay more readable.

ENDNOTES

[1]My major focus will be on illegal drugs, not alcohol use and problems, not prescription drug misuse, and not nicotine addiction, all of which are, nevertheless, important to the physician's role in prevention and treatment.

[2]Joseph Gusfield, *Symbolic Crusade: Status Politics and the American Temperance Movement* (Urbana: University of Illinois Press, 1963) is the most perceptive analysis of symbolism and addiction. Gusfield, *The Culture of Public Problems: Drinking, Driving and Their Symbolic Order* (Chicago: University of Chicago Press, 1981) is useful for understanding our blameful nature. David Musto, *The American Disease* (New York: Oxford University Press, 1987) details the extent to which drug laws were enacted in response to anti-Chinese and anti-Black

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sentiment (the 1914 Harrison Act) and anti-Mexican attitudes (the 1937 Marijuana Tax Stamp Act). For a general perspective of prohibition movements, see Robin Room, "Drug Policy Reform in Historical Perspective: Movements and Mechanisms," *Drug and Alcohol Review* 10 (1991): 37–43, and Harry G. Levine and Craig Reinarman, "From Prohibition to Regulation: Lessons from Alcohol Policy for Drug Policy," *The Milbank Quarterly* 69 (3) (1991): 461–94.

[3]Addicts and addiction are used throughout this paper even though current medical terminology uses the general term "psychoactive substance use disorders" with subcategories for abuse and dependence. The main problem with choosing addiction terminology is that it refers primarily to the drug dependency and does not convey the marked heterogeneity in usage patterns (for example, episodic intoxication, occasional use—"chippers," nonharmful use). As used in this paper, addiction is not meant to exclude general designations such as "harmful use" or "drug problems."

[4]David C. Lewis and Norman E. Zinberg, "Narcotic Usage, II: A Historical Perspective on a Difficult Medical Problem," *The New England Journal Of Medicine* 270 (14 May 1964): 1045–50. Norman E. Zinberg and David C. Lewis, "Narcotic Usage, I: A Spectrum of a Difficult Medical Problem," *New England Journal of Medicine* 270 (7 May 1964): 989–93.

[5]*New England Journal of Medicine* 270 (7 May 1964): 989–93.

[6]Ibid., 993.

[7]David C. Lewis, "Health and Privacy: The Confidentiality of Drug Treatment Records," *Contemporary Drug Problems* (Fall 1975).

[8]A.M. Rosenthal, "On My Mind-Politicians of Silence," *The New York Times,* 13 March 1992.

[9]Harry J. Anslinger and Will Oursler, *The Murderers: the Story of the Narcotic Gangs* (New York: Farrar, Straus and Cudahy, 1961).

[10]V.P. Dole and M. Nyswander, "A Medical Treatment for Diacetylmorphine (heroin) Addiction—a Clinical Trial with Methadone Hydrochloride," *Journal of the American Medical Association* 193 (8) (1965): 646–50.

[11]Countering the objection to substituting one addiction for another, recent research has produced buphrenorphine, a new drug which has many of the benefits of methadone as a maintenance drug, while producing a lesser degree of dependence. See Fudala, Jaffe, Dax, and Johnson, "Use of Buphrenorphine in the Treatment of Opioid Addiction," *J. Pharmacology and Therapeutics* 47 (4) (1988b): 47–53, and Rolley E. Johnson, Jerome H. Jaffe, and Paul J. Fudala, "A Controlled Trial of Buphrenorphine Treatment for Opioid Dependence," *Journal of the American Medical Association* 267 (8) (1992): 2750–55.

[12]Thomas D'Aunno and Thomas E. Vaughn, "Variations in Methadone Treatment Practices: Results from a National Study," *Journal of the American Medical Association* 267 (2) (8 January 1992): 253–58.

[13]Vincent Dole, who pioneered in the development of methadone maintenance treatment, is very concerned about the degree of excess regulation and lack of traditional medical values in methadone programs. He articulates these concerns in a commentary entitled "Hazards of Process Regulation-The example of

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Methadone Maintenance," *Journal of the American Medical Association* (22/29 April 1992): 2234–35.

[14]C. Stratton Hill, Jr. and William S. Fields, eds., "Drug Treatment of Cancer Pain in a Drug-Oriented Society," *Advances in Pain Research and Therapy 11* (New York: Raven Press, 1989).

[15]John P. Morgan, "American Opiophobia: Customary Underutilization of Opioid Analgesics," *Advances in Pain Research and Therapy* 11 (1989): 181–95.

[16]Norman E. Zinberg, *Drug, Set, and Setting: The Basis for Controlled Intoxicant Use* (New Haven: Yale University Press, 1984).

[17]Underprescribing is not the only aspect of physician prescribing of controlled substances. A few physicians (still a rarity) knowingly or carelessly overprescribe controlled substances. In addition, street addicts often seek drugs from physicians by feigning illness.

[18]Jerome J. Jaffe and William R. Martin, "Opioid Analgesics and Antagonists," in Alfred Goodman Gilman, Louis S. Goodman, Theodore W. Rall, and Ferid Mural, eds., *The Pharmacological Basis of Therapeutics* (New York: Macmillan, 1985, 7th rev. ed.), 511.

[19]Jerome J. Jaffe in C. Stratton Hill, Jr., et al., "Drug Treatment of Cancer Pain in a Drug-Oriented Society," 166.

[20]*Acute Pain Management: Operative or Medical Procedures and Trauma, Clinical Practice Guideline*, AHCPR Pub. No. 92–0032 (Rockville, Md.: Agency for Health Care Policy and Research, Public Health Service, US Department of Health and Human Services, February, 1992).

[21]One assumes that if permitted, a physician's prescription for marijuana would be highly regulated to prevent diversion for nonmedical usage.

[22]Lester Grinspoon, "Legalizing Drugs for Medical Purposes," in Arnold S. Trebach and Kevin B. Zeese, eds., *New Frontiers in Drug Policy* (Washington, D.C.: The Drug Policy Foundation, 1991), 246–49.

[23]*The New York Times,* 19 March 1992.

[24]Richard E. Doblin and Mark A.R. Kleiman, "Marijuana as Medicine: A Survey of Oncologists," in Trebach et al., *New Frontiers in Drug Policy,* 242–45.

[25]*The New York Times,* 22 March 1992.

[26]Fred Krueger, "Professionals see Violence as Public Health Issue," *Hospital News* (July 1987): 16.

[27]Quoted in Valerie Adler, "Roots of Violence," *Harvard Public Health Review* (Winter 1991): 5–11.

[28]The longitudinal development study conducted by Felton Earls is described in *Harvard Public Health Review* (Winter 1991): 5–11. See also Felton Earls, "An Epidemiological Approach to the Causes and Control of Violent Behavior," in Lewis P. Lipsitt and Leonard L. Mitnick, *Self-Regulatory Behavior and Risk Taking: Causes and Consequences* (Norwood, N.J.: Ablex Publishing Company, 1992).

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[29]James A. Inciardi, "The Crack-Violence Connection Within a Population of Hard-Core Adolescent Offenders," in Mario De La Rosa, Elizabeth Y. Lambert, and Bernard Gropper, eds., *Drugs and Violence: Causes, Correlates, and Consequences,* NIDA Research Monograph 103, US DHHS Pub. No. ADM 91–1721 (Rockville, Md.: Alcohol, Drug Abuse, and Mental Health Administration, Public Health Service, National Institute on Drug Abuse, 1990), 92–111.

[30]Paul J. Goldstein, H.H. Brownstein, P.J. Ryan, and P.A. Bellucci, "Crack and Homicide in New York City, 1988: A Conceptually Based Event Analysis," *Contemporary Drug Problems* (Winter 1989): 651–87.

[31]"Alcohol and Violence," *The Lancet* 336 (17 November 1990): 1223–24, and Brad J. Bushman and Harris M. Cooper, "Effects of Alcohol on Human Aggression: An Integrative Research Review," *Psychological Bulletin* 107 (3) (1990): 341–54.

[32]*Alcoholism and Drug Abuse Weekly* 4 (4) (22 January 1992): 1.

[33]Larry Culpepper, M.D., M.P.H., personal communication.

[34]Sidney Schnoll, M.D., Ph.D., personal communication.

[35]Linda C. Mayes, Richard Granger, Marc H. Bornstein, and Barry Zuckerman, "The Problem of Prenatal Cocaine Exposure: A Rush to Judgment," *The Journal of the American Medical Association* 267 (3) (15 January 1992): 406–408.

[36]*The Journal of the American Medical Association* 267 (3) (15 January 1992): 408. Also see *The Boston Globe,* 14 May 1992.

[37]Cocaine estimate reported in Ira J. Chasnoff, "Drug Use and Women: Establishing a Standard of Care," *Annals of the New York Academy of Sciences* 562 (1989): 208–10, and *American Medical News,* 6 October 1989.

[38]Quoted in the *Detroit Free Press,* 13 May 1990. Note, Bennett estimated in the *National Drug Control Strategy for 1989 and 1990* (the official publication of the Office of National Drug Control Policy) that there were "100,000 cocaine babies," a lower estimate for which there is also no scientific back-up. For an enlightening analysis of how misinformation is carried forward as a national story affecting policy decisions at the highest levels of government, I recommend the study by Stuart Hall and colleagues, *Policing the Crisis: Mugging, the State, and Law-in-Order* (New York: Holmes & Meier, Inc., 1978).

[39]Speech given at Tufts Medical School, June 6, 1990, reported in *The Boston Globe,* 7 June 1990.

[40]Wendy Chavkin, "Mandatory Treatment for Drug Use During Pregnancy," *Journal of the American Medical Association* 266 (11) (18 September 1991): 1556–61.

[41]Board of Trustees, American Medical Association, "Legal Interventions During Pregnancy: Court-Ordered Medical Treatments and Legal Penalties for Potentially Harmful Behavior by Pregnant Women," *Journal of the American Medical Association* 264 (20) (28 November 1990): 2663–70, and American Society of Addiction Medicine, Inc., *Public Policy Statement on Chemically Dependent Women and Pregnancy,* September 1989.

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[42]NIDA, 1992, *National Household Survey,* and Patrick R. Clifford, "Drug Use, Drug Prohibition and Minority Communities," *The Journal of Primary Prevention* 12 (4) (1992): 297–310 (forthcoming). On May 14, 1992, the *New York Times* reported the third consecutive quarterly rise in hospital emergencies from cocaine and heroin use; up 13 percent for cocaine and 10 percent for heroin.

[43]The Joint Committee on New York Drug Law, *The Nation's Toughest Drug Law: Evaluating the New York Experience* (New York: The Association of the Bar of the City of New York and the Drug Abuse Council, Inc., 1977), 7.

[44]Dean R. Gerstein and Henrick J. Harwood, eds., *Treating Drug Problems, vol I,* published by the Institute of Medicine (Washington, D.C.: National Academy Press, 1990).

[45]Elaine Shannon, "A Losing Battle," *TIME* (3 December 1990): 44–48.

[46]*American Journal of Public Health* 79 (3) (March 1989): 360–64.

[47]"Broadening the Base of Treatment for Alcohol Problems; A Report of a Study by a Committee of the Institute of Medicine" (Washington, D.C.: National Academy Press, 1990), and Gerstein et al., *Treating Drug Problems, vol I.*

[48]For more information contact Ellen Weber at the Legal Action Center, 236 Massachusetts Avenue, NE, Suite 504, Washington, D.C. 20002, and Christine Lubinski at the National Council on Alcoholism and other Drug Dependency, 1511 K Street, NW, Suite 320, Washington, D.C. 20005. Responding to increases in harmful cocaine and heroin use, and to criticism from addiction professionals, the Administration has recently requested a modest increase in treatment and prevention funding from 25 percent to 32 percent, *New York Times,* 14 May 1992.

[49]Nicotine and beverage alcohol consumption in the United States are on the way down. The documented shift in attitudes caused in large part by public education has played a major role in the trend. We can presume that within the drop in use is also a drop in harmful use. This is certainly the case for cigarette smoking which is arguably the only instance where, from a medical/public health prospective, most use is harmful use.

[50]It is of interest that proponents of enforcement and regulatory approaches now receive support from revisionist analyses of Prohibition. See Mark H. Moore, "Actually, Prohibition was a Success," *New York Times,* 16 October 1989, A21, and Richard H. Schwartz, "Prohibition, 1920–1933: An Overview of its Effects on Public Health and the Economy," *Southern Medical Journal* 85 (4) (1992): 397–402.

[51]Steven Jonas, "Solving the Drug Problem: A Public Health Approach to the Reduction of the Use and Abuse of Both Legal and Illegal Recreational Drugs," *Hofstra Law Review* 18 (3) (Spring 1990): 751–93. For one version of a public health oriented goal see Jonas, 786, "Reduce and control the use of all the recreational mood-altering drugs to provide for their safe, pleasurable use, consistent with centuries-old human experience, while minimizing their harmful effects on individuals, the family, and society as a whole." See also Steven Jonas, "Should Public Health Adopt a Harm Reduction Drug Control Strategy?" paper given on November 12, 1991 at the 1991 American Public Health Association Annual Meeting to the Council on Illicit Drug Policy. An excellent comprehensive

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discussion of the public health approach is found in "Public Health Approach to the Prevention of Substance Abuse," in Joyce Lawirson, Pedro Ruiz, and Robert Millman, *Substance Abuse: A Comprehensive Textbook,* second edition (Baltimore, Md.: Williams and Wilkins, 1992): 928–43.

[52]For thoughtful discussion of the implications of medicalization, see David A.J. Richards, "Drug Use and the Rights of the Person. . . Symposium on Punishment: Critiques and Justifications," *Rutgers Law Review* 33 (1981): 607–86, and Robert J. Levine, "Medicalization of Psychoactive Substance Use and the Doctor-Patient Relationship," *The Milbank Quarterly* 69 (4) (1991): 623–40.

[53]Richard Lawrence Miller, "When Children are Involuntary Research Subjects," *The Drug Policy Letter* 3 (4) (Fall 1991): 5–7.

[54]For more information contact The Drug Policy Foundation, 4801 Massachusetts Ave., NW, Suite 400, Washington, D.C. 20016–2087, and The Criminal Justice Policy Foundation, 2000 L. Street, NW, Suite 702, Washington, D.C. 20036. It is worth noting that the Drug Policy Foundation is reaching out to medical professionals for its Fall 1992 conference, November 11–14, 1992, in Washington, D.C.

[55]For further references see A.R. Jonsen, "Do No Harm," *Annals of Internal Medicine* 88 (1978): 827–32.

[56]Norman E. Zinberg, and John A. Robertson, *Drugs and The Public* (New York: Simon and Schuster, 1972), 58–86, and Richard Jacobson and Norman E. Zinberg, *The Social Basis of Drug Abuse Prevention* (Washington, D.C.: The Drug Abuse Council, 1975) and Zinberg, *Drug, Set, and Setting.*

[57]Dwight Heath, "Prohibition or Liberalization of Alcohol and Drugs: A Sociocultural Perspective," in Marc Galanter, ed., *Recent Developments in Alcoholism,* vol. 10 (New York: Plenum Press, 1992), 129–45.

[58]Conclusion of the National Commission on Marijuana and Drug Abuse in 1973: "Unfortunately, 60 years of coercive policy have so exaggerated this symbolic importance of the criminal law that it has become interwoven with social attitudes regarding drug use. Removing it suddenly would connote a change in values rather than merely a shift in emphasis." (Second Report of the National Commission on Marijuana and Drug Abuse, 1973), 255–56.

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*Mark Schlesinger and Robert A. Dorwart*

# Falling Between The Cracks: Failing National Strategies for the Treatment of Substance Abuse

BY INTERNATIONAL STANDARDS, medical care in the United States is delivered and financed in an extraordinarily complicated fashion. Health services are provided in an array of inpatient and outpatient settings, each with a different mix of for-profit, private nonprofit, and public facilities. Services are paid for by thousands of different private insurance companies, as well as federal, state, and local governments. These arrangements have faced intense criticism in recent years, on the grounds that they fail to provide many individuals adequate health care while exacerbating medical costs. Nonetheless, they continue to have staunch defenders, particularly in Washington. The current mix of providers and financing systems is portrayed as an embodiment of pluralistic American values, a mechanism for allowing different models of medical care to compete in the marketplace, and a bastion against overly intrusive interventions by government into what are appropriately private choices.[1]

But pluralism has its costs. And these are perhaps nowhere so graphically portrayed as in the failure to develop effective national policy involving the treatment of substance abuse. Despite significant expansions of private insurance coverage over the past decade and significant increases in government funding in the past five years,

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existing arrangements for financing and treating substance abuse fail to meet established national goals. These shortcomings have not improved with additional funding. They are inextricably linked to the fragmented nature of the existing system. Fragmentation worsens the performance of the treatment system. Key decisionmakers have little incentive to improve the system, since they typically bear the full costs of the improvements, but are not rewarded for their achievements. Fragmentation hamstrings efforts by policymakers either to assess or to improve this performance.

For the past half dozen years, substance abuse has been a primary concern of the American public and of federal policymakers. Beginning in the mid-1980s, public opinion surveys ranked substance abuse among the most important problems facing this country.[2] Voters in the 1988 presidential election were strongly influenced in their choice between Bush and Dukakis by their perceptions of how each candidate would deal with the drug crisis.[3] This concern was not missed in Washington. The first federal response aimed at enhancing treatment was the 1986 Anti-Drug Abuse Act. As part of this legislation, Congress requested that the Institute of Medicine develop guidelines for improving the treatment system, which it did in 1990 with its report *Treating Drug Problems*. Shortly after he entered office, President Bush declared the latest "war on drugs." The Office of Treatment Improvement was established to assist state efforts to rationalize the treatment system.[4] Since 1989, the White House has issued annually a volume entitled the *National Drug Control Strategy*. Much of this document is devoted to the treatment system.

This domestic war has proven far less tractable than recent international conflicts. This has been particularly true for efforts to increase the effectiveness of the treatment system. Federal officials have recently proclaimed partial victory on the basis of surveys indicating a decline over the past several years in the use of illicit substances. These declines, however, have been almost exclusively in casual or experimental use. These drug users are rarely in treatment. The number of heavy drug users—those who most need treatment and are most commonly in treatment—has in fact grown over this same period.[5] So too have the number of adverse outcomes. In the last quarter of 1991 (the latest period for which data is available) there was a 13 percent increase in the number of people going to

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hospital emergency rooms as a result of adverse reactions to cocaine use and a 10 percent increase in adverse reactions to heroin use.[6]

Indeed, the current treatment system fails badly by most reasonable standards of performance, especially in terms of the ability of drug users to obtain treatment in a timely fashion, sometimes termed "treatment on demand." There is a clear national consensus that this is an appropriate goal for the treatment system.[7] Two-thirds of those responding to a nationwide public opinion survey in 1988 reported that they would be willing to pay more taxes for "the expansion of drug rehabilitation centers so that any addict can be immediately admitted for treatment."[8]

Treatment capacity in the United States falls far short of this standard. The National Association of State Alcohol and Drug Abuse Directors has estimated that only 15 to 20 percent of all serious drug abusers received treatment in 1991. Although a substantial number of heavy drug users do not seek treatment, many others were unable to gain access to treatment facilities.[9] Treatment capacity, relative to need, declined significantly from the early 1970s through the mid-1980s and recent expansions have only partially closed this gap.[10] Anecdotal reports and surveys of state officials suggest that drug users seeking treatment often face long waits before they can enter a program, in part due to large differences in capacity from one community to another.[11] The most comprehensive assessment of these delays is provided by data from the Drug Abuse Services Research Survey (DASRS), fielded in the summer of 1990 under the auspices of the National Institute on Drug Abuse (NIDA). Of all the facilities responding to the survey, 42 percent usually had more applicants for treatment than they could accept. Nationwide, over 100,000 drug users are reported having to wait for treatment. This is true even for intravenous drug users, the group that Congress assigned the highest priority for treatment in an effort to stem the spread of Acquired Immune Deficiency Syndrome (AIDS).[12]

Other failures are evident as well. Existing arrangements for financing and providing drug treatment do little to foster the expansion of the most effective methods of treatment. In fact, they appear sometimes to encourage exactly the opposite outcomes. For example, the Institute of Medicine report concluded that there was little evidence that hospital-based programs were particularly effective, but saw more promise in longer term residential programs. Over the past

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decade, however, hospital-based drug treatment has expanded significantly, while residential programs remain static, with a capacity to admit less than 5 percent of those receiving treatment for substance abuse.[13]

The current treatment system has also been slow to respond to changing forms or consequences of substance abuse. Perhaps the most publicized illustration of this failure involves pregnant women. Policymakers have grown increasingly concerned with this group following the spread of crack cocaine and the apparent rise in the number of children born with cocaine addiction and neurological impairments.[14] But women, particularly when pregnant, have a hard time finding a program to treat them. Despite efforts by Congress to give special priority to this group and efforts by the National Institute on Drug Abuse to fund demonstration projects in this area, pregnant women still face significant barriers to obtaining treatment.[15] Problems of access are particularly acute for residential treatment programs, a critical problem since experts suggest that up to half of pregnant women with serious drug dependencies would be best treated in residential settings. Less than 40 percent of the treatment programs surveyed in 1990 on the DASRS were treating any pregnant women.

To the extent that we are indeed fighting a war involving drugs, we are losing on the treatment front. Drug abuse treatment in the United States appears to consistently underserve particular communities, particular modes of treatment, and particular groups of drug abusers. These failures do not reflect a lack of awareness by policymakers. Each annual White House report touches on these problems. Congress has repeatedly passed legislation meant to address these gaps. In our assessment, however, these efforts are doomed to failure because they focus on tactics rather than strategy. Even those reports explicitly designed to address strategic questions ignore fundamental flaws in the system upon which these strategic plans rest. Attempts to formulate effective national strategies cannot succeed unless they address the ambiguities and inconsistencies that are inherent in existing arrangements for financing and treating substance abuse. The pluralistic nature of our attitudes about drug abuse and our methods for dealing with this problem are in themselves perhaps the most daunting challenge for policymakers.

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The current system has evolved in several stages over the past forty years. At each stage, different notions prevailed about what constituted appropriate treatment and who should assume responsibility for financing this treatment. One major perspective has been described as the "medical model" of treatment, characterizing drug abuse as a disease. A second competing perspective has been termed the "criminal justice model," portraying drug use as primarily a failure of personal values and social norms.[16] These different philosophies persist within different portions of the system today. As a result, the current system is a hodgepodge of philosophies and practices. It is a "system" only in the ecological sense, with different entities interacting with one another. There is virtually no collective planning or cooperation. This makes it difficult to make operational broadly accepted strategic goals, such as treatment on demand.

Efforts to construct an effective national strategy are challenged by more than philosophical differences. As treatment capacity has developed under different auspices, many providers have little or no contact with the government agencies that are intended to oversee the treatment system. Data gathering systems that previously tracked basic measures of system performance were abandoned or became outmoded. Policymakers are thus forced to develop strategies in the absence of reliable information about the amount of capacity that currently exists, its geographic distribution, or the number of people in various forms of treatment. It is as if a military campaign is being waged by generals who are not only ignorant of the strength and disposition of the enemy, but also unaware of the capacity of their own forces.

Even with better data, effective national policies face one more formidable hurdle. Providers in each segment of the treatment system respond to very different types of incentives and influences. Within the military metaphor, there is no effective chain of command, because different providers interpret each command differently. Consequently, policies that are appropriate for one portion of the system may have little influence on other portions. Attempts to expand or reconfigure one portion of the system can create repercussions in other parts of the system which can undo the intended effects of the intervention. When policymakers recognize these unintended side effects and attempt to prevent them, they create policies that further undermine the efficacy of the treatment that they finance. Adding to

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these problems, the treatment system in different communities has expanded at different rates over the past several decades. As a result, the mix of providers and payment arrangements differs significantly from one part of the country to another. Federal policies that are sensible in some areas may be ineffective or inequitable in others.

All these challenges to effective policy-making—conflicting goals, inadequate information, inconsistent responses by treatment providers—can, in our assessment, be traced to a more fundamental strategic error: an attempt to structure the drug treatment system along the pluralistic lines common to most health and human services in the United States. We trace here the historical development of this heterogeneity. We document how, as arrangements for treating drug abuse and financing that treatment grew more complex, portions of the treatment system slipped out of policymakers' sight. We then show how policies based on this limited understanding miss some of the most important dynamic aspects of the system, aspects that can undermine the effectiveness of policies intended to expand capacity for particular groups of drug abusers. After this review we consider a very different strategic approach. This new strategy moves policy-making away from the traditional medical or criminal justice models toward what could be termed a public health or public utility model. It would redefine what we expect from the system of drug treatment as well as how policymakers should guide the performance of that system.

## THE EVOLUTION OF THE CURRENT TREATMENT SYSTEM

Prior to the late 1800s, most Americans viewed the use of addictive substances as a matter of individual choice. This libertarian perspective began to give way about a century ago, as a byproduct of efforts to stem international trafficking in opium and in response to growing concerns about the medical and social problems associated with substance abuse.[17] The treatment system that exists today emerged almost entirely after World War II. The system grew sporadically. In each period of expansion, somewhat different norms prevailed about how to treat substance abuse and who should pay for this treatment.[18]

The first significant expansion of treatment for drug abuse occurred in the early 1960s. This built on models developed earlier.

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One set of treatment sites was within prisons. Two treatment centers had been established within the federal prison system, one at Lexington, Kentucky, the other at Fort Worth, Texas, during the late 1930s. Although primarily intended to serve federal prisoners convicted on narcotics charges, they were also open to those who were voluntarily admitted without a criminal conviction. As drug use expanded in the early 1960s, state officials, most notably in New York and California, responded by establishing civil commitment laws to force drug users into treatment programs comparable to federal models. This began a major state role in financing treatment services.

A second approach to treatment involved drug users participating in long-term self-help groups, often based on the twelve step program associated with Alcoholics Anonymous. These programs sought to reshape the norms of participants, often by invoking values based on religious beliefs. Some of these programs involved residential arrangements, termed "therapeutic communities." Others involved frequent group meetings by individuals who maintained their own residences.

Although superficially different, these two approaches to treatment shared several important commonalities. Most of the funding for formal treatment programs came from state and federal governments, though mutual-assistance groups were often supported by private nonprofit community agencies and churches. Both approaches drew heavily on the criminal justice model of treatment. This portrayed drug users as deviant from societal norms and asserted that drug abuse could be most effectively reduced by bolstering norms of appropriate behavior. In the prison system, this involved the threat of incarceration; therapeutic communities, on the other hand, were "self-policing" in the sense that those who violated group-defined norms ran the risk of exclusion from the fellowship of the group. Both approaches involved treatment of extended duration. Prisoners were often incarcerated for a prolonged period, which facilitated longer term treatment. Therapeutic communities established norms of between one and three years residence for full participation. Mutual-help groups sought to involve participants in a lifetime contract: substance abusers never recovered, they were always "recovering."

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A significant shift in approach to drug treatment occurred in the late 1960s and early 1970s. Methadone maintenance programs began to be widely established during this period. There was also an expansion of formal treatment programs that dealt with drug addiction on an outpatient basis (sometimes termed outpatient "drug-free" programs). The first of these programs involved a limited number of community agencies created to provide aftercare for prisoners released on parole.[19] This focus was soon expanded to drug users who had never been incarcerated. Preexisting community agencies, such as the community mental health centers (CMHCs) created by the 1963 Community Mental Health Act or community action agencies established by the Office of Economic Opportunity (OEO), were encouraged or required to add programs for the treatment of substance abuse. This introduced a new twist to the treatment system: agencies that provided drug treatment as a "sideline" rather than as their central mission. These nonspecialized providers were to play an increasingly important role in the treatment system over time.

At a philosophical level, these changes reflected a partial shift from the criminal justice to the medical model of treatment. Treatment more often involved pharmacological or psychological interventions. More subtly, policymakers began to see drug treatment as a short-term rather than long-term intervention, drug abuse as an acute rather than chronic problem. This redefinition was reflected in the implementation of methadone programs. Originally conceived primarily as providing long-term maintenance for heroin addicts, the programs were implemented under regulations that required extensive therapy and limited doses in an effort to wean drug users off the program over time.[20]

Although there was a significant expansion in the number of community-based treatment programs during this period, the federal government was largely successful at maintaining accurate information about the scope and performance of the treatment system because virtually all provider agencies had some direct funding from the federal government. The CMHCs and OEO agencies relied primarily on federal funding. Special initiatives under the Nixon Administration in the early 1970s involved the Special Action Office for Drug Abuse Prevention directly contracting with other community-based treatment programs to provide funding to eliminate their waiting lists. Once the National Institute on Drug Abuse was

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established in 1973, it maintained the Drug Abuse Reporting Program through which it collected longitudinal data on clients' treatment and outcomes. Given information and financial leverage, federal authorities were successful at shaping the mix and extent of services available in local communities.[21] Based on their assessment of the relative effectiveness of different programs, they deemphasized hospital-based programs in favor of outpatient programs.[22]

Through the end of the 1970s and the first years of the 1980s, the American drug treatment system underwent one more period of substantial change. This transformation reflected two trends. These were seemingly unrelated, though as we shall suggest later, were actually linked. The first change involved a shift in public policy, and thus in the nature of publicly financed treatment services. The second involved a remarkable expansion of private financing and authority for drug treatment.

The extent of federal control over the treatment system steadily declined during this period. This was presaged by a decline in federal financial support for the agencies providing drug treatment. Federal funding for some agencies, such as community mental health centers, had always been intended primarily as "seed money," to be subsequently replaced by other financial resources. As federal funding decreased, agencies were less inclined to honor federally established requirements or to participate in costly data reporting systems.

There was also a shift in prevailing opinion among federal policymakers toward programs that gave greater administrative authority to state governments. In 1981, Congress enacted the Alcohol, Drug and Mental Health Services (ADMS) block grant largely to relieve states of administrative requirements and to increase their flexibility in allocating resources. This transfer of administrative responsibility was intended to be matched by a shift in fiscal responsibility, with reductions in federal spending offset by additional state funding. Not surprisingly, states were less enthusiastic about this part of the deal. Many not only failed to augment their past funding, they took advantage of reduced federal oversight to cut back on spending. Federal funding for drug treatment declined from $250 million annually in the mid-1970s to roughly $175 million a year in the early 1980s. State and local funding dropped even more precipitously, from over $280 million a year to about $175 million during this same period. These spending cuts led to both a reduction in aggregate

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treatment capacity and a growing emphasis on short-term treatment. By the mid-1980s, the average duration of treatment for a client in an outpatient drug-free program was under four months. Since most of those in treatment were admitted to these programs, such short-term interventions became the standard for the publicly-funded treatment system.

While states resisted an expanded role in paying for the treatment of substance abuse, they provided a major impetus for a shift in financing from public to private auspices. This was at first largely unintentional. Beginning in the early 1970s, states began to require that private insurers operating in their jurisdiction cover particular services. These so-called "mandated benefits" had great appeal for state legislators, since they expanded health benefits for their constituents without raising taxes.[23] Hundreds were enacted during the 1970s and early 1980s. Among the most common of these mandated benefits involved coverage of mental health care.[24] These mandated benefits were relatively modest, generally covering between twenty and forty-five days of inpatient treatment and ten to twenty visits for outpatient care. Nonetheless, they represented a significant expansion, since mental health care had previously been excluded from most private insurance policies. Because many insurance plans included substance abuse under the general provisions for mental health care, insurance coverage for drug treatment expanded as well. At this time, however, most state legislators were not yet thinking about substance abuse treatment in these terms.

By the early 1980s, policymakers and private decisionmakers were growing more concerned about the spread of drug abuse among the middle and upper classes.[25] With most private insurance provided as a fringe benefit of employment, employers' perceptions played an important role. Many employers became convinced that drug abuse was hurting productivity; this led them to establish employee assistance programs to help detect drug use and expanded insurance coverage to pay for treatment.[26] Federal policies fostered employer concerns by requiring drug testing in some work settings; by the end of the 1980s, a third of large businesses were testing employees or job applicants for drug use.[27] State officials felt similar concerns and began to enact mandated benefits that explicitly covered the treatment of substance abuse.[28] These requirements largely emulated those established earlier for mental health care benefits.

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At the end of the 1980s, about two-thirds of all medium and large businesses (employing three-quarters of all workers) covered some treatment of substance abuse as part of their employer-based policies, though perhaps as many as a fifth of these policies covered only short-term hospitalizations for detoxification.[29] The growth of private insurance led to a marked shift in the balance of financing drug treatment from public to private auspices. In 1976, only 5 percent of all revenues in treatment programs came from private sources. By 1980, this had grown to about 10 percent, with insurance providing about half of the private financing. By 1989, revenues from private sources covered more than 40 percent of all drug treatment; private insurance alone paid for more than 30 percent.

This dramatic expansion of private insurance coverage led directly to a shift in types of treatment. Hospital-based treatment, largely rejected by public officials, reemerged as a form of treatment. The number of patients receiving hospital treatment for drug abuse on any given day grew from 2,600 in 1980 to 13,300 in 1989. Sixty percent of all private insurance payments for drug treatment in 1989 went to hospital-based programs.[30]

Private insurance was linked to hospital-based treatment for several reasons. Mandated benefits tended to be more generous for inpatient than outpatient treatment. Providers developed hospital-based treatment plans (such as the "Minnesota" or "twenty-eight day" plans) that coincided nicely with the limits of these benefits. (Many of these programs were in community general hospitals—the number of these hospitals with chemical dependency units more than doubled between 1980 and 1986—which were suffering from low occupancy rates.[31]) Most insurers were unfamiliar with the drug treatment field and tended to feel more comfortable with hospital-based programs that resembled the types of medical care that they had experience purchasing.

This final wave of expansion had a number of implications for prevailing notions of the role and scope of drug treatment. Drug abuse was increasingly treated like other medical conditions.[32] Covering drug treatment under private health insurance led to increased treatment in medical facilities (hospitals), increased requirements for physicians to supervise treatment, and increased use of utilization management techniques that were designed for other types of medical care. This was associated with an increasing role for nonspecial-

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ized providers, who saw drug treatment as a lucrative market to add to their existing lines of business.[33] As short-term treatment became the norm (driven by insurance limitations in the private sector and budget constraints in the public sector), drug abuse was increasingly seen as an acute medical condition.

During the latest transformation, our collective picture of the treatment system also grew considerably fuzzier than it had been in the past. As the federal government transferred responsibility for funding and oversight to the states, it neglected to establish clear requirements for how states were to monitor the system. As one study of the implementation of the ADMS block grant noted, "gone are many prior specifications having to do with the exact configuration of the service system, preparation of comprehensive planning documents, and other federal requirements."[34] Officials in many states concluded that their responsibility was simply to dole out the money and devoted few resources to monitoring the nature or the quality of the treatment they were purchasing.

In the absence of regular and reliable measures of government-funded drug treatment, cutbacks in federal and state funding could proceed with little adverse publicity. This served the interests of officials in the Reagan Administration intent on reducing federal domestic spending. But when the federal government accepted the need to expand treatment capacity in the latter half of the 1980s, it was faced with unreliable statistics about the capacity that was already being supported, making it difficult to determine how to set priorities in allocating additional resources among states.[35] Moreover, privately insured treatment often occurred in facilities that did not have a distinct program for treating substance abuse, or at least not one that received state funding. These facilities were not even included in state surveys of treatment capacity.

Perhaps the most significant consequence of the growth of privately insured treatment, however, involved a shift in the allocation of responsibility for drug treatment. As the federal government abandoned its role overseeing the treatment system and many states assumed only limited oversight, private purchasers became the most active influence on the system. This influence reflected two sets of interests. Employers balanced the effectiveness of drug treatment for improving the productivity of their work force against the costs that it added to health insurance as a fringe benefit.[36] Insurers applied the

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utilization management techniques that they had developed for controlling other medical costs. These generally emphasized reducing length of stay in treatment, further redefining substance abuse as an acute condition.[37]

The treatment system in the early 1990s embodies all three of these past periods of growth. Although the prevailing perception of drug treatment changed with the introduction of each new form of treatment or financing arrangement, the norms and practices associated with each period of expansion to some extent persisted within that portion of the treatment system. Currently, there are a substantial number of clients in treatment for substance abuse in prisons or in therapeutic communities, modalities dating back to the earliest incarnations of the treatment system.[38] Although these programs have to some extent evolved from their initial models—a number of therapeutic communities have, for example, been developed with less religious or controlling orientations—they often maintain important elements of the criminal justice perspective, with strong emphases on personal responsibility and nondeviant behavior. Similarly, the implicit definitions of appropriate treatment common to the privately financed portion of the treatment system established during the 1980s often differ significantly from those prevailing for the publicly-financed treatment created during the 1970s. With about a third of all drug treatment financed through private sources, this represents a significant split in the system.

These differences in treatment practices are accompanied by different sets of motivations. As we will discuss shortly, private actors (employers or insurers) responsible for one portion of the treatment system have very different objectives than do public officials responsible for other forms of treatment. As a result, public policies designed to change the scope or nature of treatment must recognize these differences. Policies that produce the appropriate incentives to improve treatment in one portion of the system may lead to counterproductive outcomes among a different set of providers or financing arrangements.

The contemporary drug treatment system in the United States is thus fragmented along a number of fault lines. Recent prescriptions for policy reform have begun to recognize some of the implications of these divisions. But these have focused almost exclusively on one crack in the system, the division between publicly and privately

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financed treatment.[39] The policy implications of other equally important distinctions—between specialized and nonspecialized providers, between criminal justice and medical models of treatment, between federal and state responsibility—have received much less attention. We consider now some of these overlooked negative implications. We will demonstrate how these various cracks in the system have compromised past efforts by policymakers to improve the effectiveness of drug treatment.

## THE CHALLENGES OF PUBLIC POLICY IN A COMPLEX TREATMENT SYSTEM

The primary goal for policymakers concerned about the treatment of substance abuse is to determine if treatment capacity is adequate, relative to need, and if clients are being matched to the treatment modalities most appropriate for their conditions. This task is made far more difficult by disagreements over who needs treatment. Equally plausible definitions produce two- to threefold differences in estimates of the population needing treatment.[40] The differences stem from disagreements over whether individuals with moderate levels of drug use should be treated and whether those with heavy use who resist treatment should be required to participate.

However these issues are resolved, the task of effective policymaking is complicated by three consequences of the currently fragmented treatment system. These involve problems in measuring capacity, problems in translating the number of existing treatment "slots" into the actual availability of treatment for individual drug users, and problems in expanding capacity through government interventions.

### *The Mismeasure of Capacity*

The standard statistics, cited by the Institute of Medicine and in the annual drug strategy reports from the White House, indicate that there are approximately 5,000 facilities in the United States treating drug abuse. Just over 1,000 provide drug treatment alone, another 4,000 treat both alcohol and drug abuse. These facilities have an estimated daily census of just under 600,000 clients; 262,000 are treated for drug abuse, the rest for alcohol abuse. These figures are compiled annually through the National Drug and Alcohol Treat-

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ment Unit Survey (NDATUS), conducted under NIDA auspices, but relying on each state to collect the data from its jurisdiction.

Although widely accepted as measures of the amount of drug treatment now being provided, these estimates are seriously flawed. They omit three sources of treatment and thus a substantial portion of national treatment capacity. Perhaps the most significant in magnitude is the omission of those participating in self-help and mutual-assistance programs. When these programs are part of therapeutic communities, they are usually included in state surveys, primarily because they are too expensive to be affordable for most individuals without some third-party assistance. To receive payments, these programs must typically obtain state certification. When in the form of community-based programs such as Alcoholics or Narcotics Anonymous, however, the programs less often receive third party reimbursement and are rarely certified. Moreover, because these programs have a strong historical tradition of maintaining confidentiality for their members, state and national associations are loath to provide even aggregate statistics on the number of participants. (Nor is it obvious, with such unstructured programs, whether a person remains an active participant if their attendance becomes sporadic.)

Clinicians disagree about whether these mutual assistance groups should be considered "treatment" in a strict sense of the term. The Institute of Medicine report referred to these groups as a "quasi-treatment" modality and noted the paucity of data documenting their effectiveness. Nonetheless, mutual self-help groups have become an intrinsic and ubiquitous part of the treatment system. They are often used as a complement for various other forms of treatment, such as the twenty-eight day hospital programs. Participants are reimbursed by at least some private insurance plans. Extrapolating from reported participation levels in some local communities suggests that as many as a million Americans may be participating in mutual assistance groups intended to curb illicit drug use.

Although the omission of these groups from national statistics on treatment capacity could be rationalized on the grounds that they are not providing treatment in a clinical sense, two other omissions are more problematic. The first involves office-based professionals—physicians, psychologists, and social workers—who treat substance abuse as a part of their clinical practices. Because there exist no

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regularly collected statistics on the case mix of many of these professionals, it is difficult to estimate the magnitude of this omission. Physicians represent the one group for which data are available. Surveys indicate that on a given day, approximately 125,000 patients are treated in a physician's office for a primary diagnosis of substance abuse.[41] About three-fourths of this treatment is provided by psychiatrists, representing on average 5 percent of their practice. (Many of these patients may have concomitant psychiatric problems.) Assuming that even a small percentage of the private practices of psychologists and social workers involves substance abuse, the estimated number of Americans treated by private practitioners could approach a quarter million.

*Perhaps the most curious omission from existing statistics involves* treatment of substance abuse in nonspecialized facilities. Over the past several decades, these facilities—most notably community mental health centers, psychiatric hospitals, and short-term general hospitals—have become an increasingly important source of treatment for substance abuse. By the late 1980s, 15 percent of the clients of community mental health centers had a primary diagnosis of substance abuse.[42] Eighteen percent of the admissions to private psychiatric hospitals and about half again as many admissions to state mental hospitals involved a primary diagnosis of substance abuse.[43] A half million admissions a year to community general hospitals involved a primary diagnosis of alcohol or drug abuse; hospitals run by the Department of Veterans Affairs averaged another 100,000 admissions for these diagnoses.[44] If one included secondary diagnoses, these numbers would be two to three times as large.

Some of this treatment in nonspecialized settings is measured in national statistics collected through NDATUS. But facilities that do not have a separate drug treatment program are likely to be omitted. Using data from a variety of sources, we have constructed estimates of the amount of facility-based treatment that has slipped between the cracks in past national estimates of treatment capacity.[45] These are portrayed in *Figure 1*.

Almost 80 percent of the inpatient treatment capacity for substance abuse is in nonspecialized facilities. Less than half of this is reported in NDATUS. Thus, while federal statistics indicate that on any given day, about 30,000 Americans are treated for substance

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abuse in inpatient settings, the actual number is closer to 50,000. About 44 percent of all outpatient treatment is in nonspecialized facilities and almost half of this is missed in the official statistics. Only for residential treatment is the omitted part of the system trivial in size. The extent of this undercounting varies by city. In some cities (for example, New York, San Francisco, Seattle or Detroit) virtually all treatment capacity is in specialized settings and thus measured with reasonable accuracy through NDATUS. In other cities, such as San Jose, San Antonio, and Boston, less than half of drug treatment occurs in specialized settings. For these latter cities, official statistics seriously undercount capacity.

These numbers represent both good and bad news. There is significantly more capacity to treat substance abuse, and a much larger number of people in treatment, than suggested by the numbers collected through NDATUS. On the other hand, virtually nothing is known about the type or quality of treatment that these clients are receiving.

The large number of patients with dual-diagnoses (problems of substance abuse and mental illness) may receive better care in a psychiatric hospital or community mental health center than they would in a facility that treated only substance abuse.[46] On the other hand, past experience suggests that treatment of conditions by nonspecialists can have its problems. For example, studies have found that many patients with mental illness are treated by general practitioners rather than mental health professionals. Although they are receiving some treatment, this is often of questionable quality, with an overreliance on medication for conditions more appropriately treated by other methods.[47] Similar problems could be expected when problems of substance abuse are treated by those not well trained in this area.

Perhaps the most serious implications of these findings, however, are at the policy-making level rather than the level of the individual patient. In the decade following the creation of the ADMS block grant, the publicly financed drug treatment system has evolved with little direction from federal and state officials, who have had at best a vague sense of the scope and practices of that system. The expansion of private insurance coverage vastly exacerbated this problem. It allowed enrollees to receive care in a broad array of medical settings. Many of these providers have little involvement

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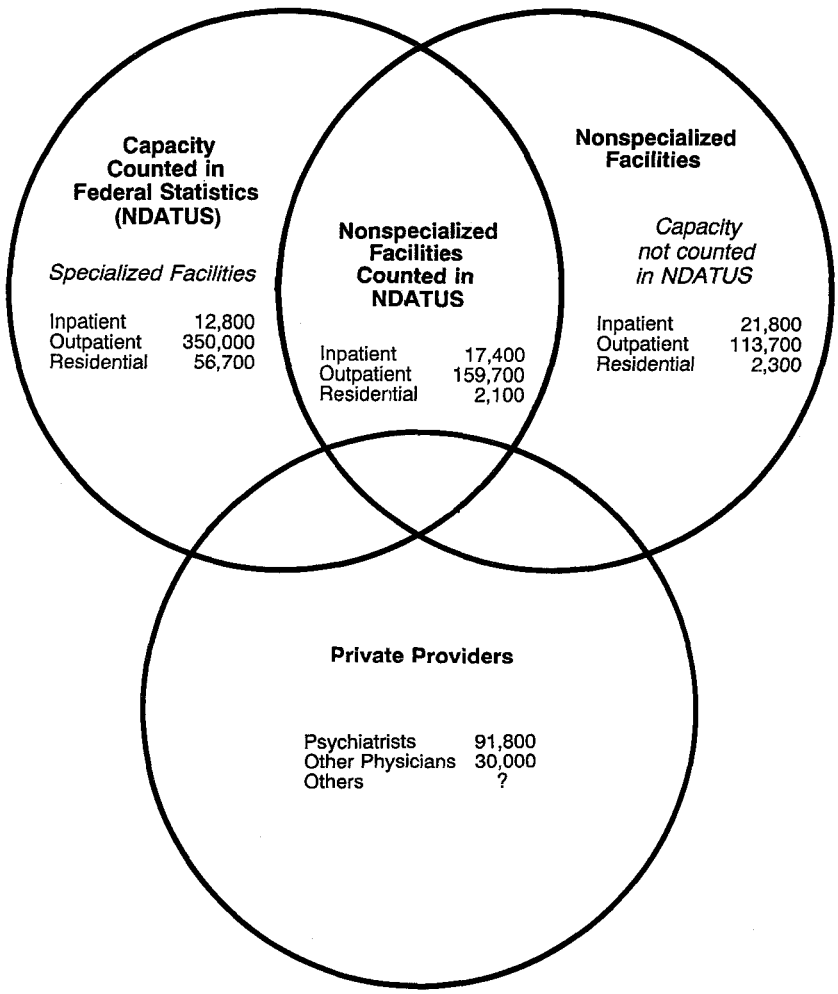
Figure 1. Treatment for Alcohol and Other Drug Abuse (Estimated Daily Census for Providers) in the United States, 1987.




with state drug programs; state officials are thus even less aware of their practices than those in the longer-established specialized treatment system.

Indeed, notions of effective public accountability become elusive when those in charge cannot even find a substantial portion of the system they are responsible for overseeing. Consider a concrete example. Let us say that Congress and the President have agreed on the need to spend an additional $1 billion in federal funds for drug

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treatment. It is further agreed that these new resources should be allocated to those cities where capacity currently falls farthest short of need. Since federal statistics on capacity omit much capacity in nonspecialized settings, cities where treatment most often occurs in these settings will appear to have too little capacity. They would thus receive a disproportionate share of funds. But when nonspecialized capacity is fully taken into account, these communities may already have substantial resources devoted to treatment. Using the cities introduced above to illustrate, if funds were allocated based solely on specialized capacity, San Jose and San Antonio would be given greater priority for additional funding than either Detroit or Seattle. When one fully counts capacity in both specialized and nonspecialized settings, however, the first two cities have substantially more treatment capacity per resident than do the latter two.[48]

In the absence of reliable measures of capacity, policymakers have been forced to rely on other less direct measures. The length of waiting lists are most commonly cited. The recommendations by the Institute of Medicine to expand treatment capacity, for example, established the goal of ending "delays in admission when treatment is appropriate, as evidenced by waiting lists."[49] In 1990, members of the Senate Committee on Labor and Human Resources explicitly requested that NIDA collect information on waiting lists that could represent the accessibility of treatment in each state.[50]

Waiting lists are at best a rather inaccurate measure of unmet need for treatment. Drug users who initially sought treatment may grow discouraged or disinterested while on the waiting list. Those who would have sought treatment, but feel that the wait is too long, may never bother to apply. These limitations are exacerbated by the fragmented nature of the treatment system. With many different provider agencies in most large communities, it behooves a drug user interested in treatment to sign up on multiple lists to increase the odds of a quick admission. Simply adding up waiting lists would then double or triple count each potential client. Providers have an incentive to inflate waiting lists to strategically enroll particular clients. Those who are interested in weeding out unprofitable or otherwise undesirable clients can put everyone on a waiting list, then selectively admit from the list without appearing to discriminate against particular individuals or types of clients. The complexity of the system and of the motives of providers thus again makes

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questionable the reliability of measures that might otherwise be appropriately used to allocate resources.

*Accessibility and Measured Capacity*

Most estimates of capacity are, in accounting terms, measures of "stocks." Inpatient or residential capacity is calculated as the number of beds; outpatient capacity as the number of treatment slots, or the caseload that the agency is licensed to provide, given its personnel and other resources. But accessibility for an individual seeking treatment, that is, the availability of treatment on demand, depends on the "flow" of patients through this capacity. This is determined by two factors: ease of admission to the program and duration of treatment. The growing complexity of arrangements for financing and treating substance abuse have made each of these factors more problematic for public policy.

The number of patients who can flow through a system of a given capacity is inversely related to the length of treatment. The typical episode is currently quite brief. Federal statistics indicate that on a given day in 1987, there were just over 250,000 clients in treatment for drug abuse. A total of 830,000 were treated over the course of the entire year.[51] The average length of treatment was thus somewhat less than four months, though this represents clients who drop out of treatment programs as well as short prescribed courses of treatment.

In each era of system growth, different norms prevailed about the appropriate duration of a treatment episode. Because different segments of the system have to some extent retained these historical standards, the contemporary treatment system embodies widely varying norms. The average duration of a treatment episode varies considerably among different modalities. Hospital inpatient programs are designed to last twenty-eight days, while most residential programs last up to a year, some considerably longer. Treatment in outpatient drug-free programs is generally intended to last six months, while most outpatient methadone programs are designed to run indefinitely. The actual duration of treatment for clients in methadone programs (roughly eight months) is more than twice as long as for clients in outpatient drug-free programs. This variation adds to existing controversy over the optimal length of treatment.

Although the optimal length of treatment likely depends on a variety of client characteristics,[52] most evidence suggests that longer

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treatment programs are more effective, reducing drug use and crime as well as increasing clients' ability to function in the community.[53] National strategy proposals involving drug treatment uniformly agree that public policy should encourage longer term programs and reduce the dropout rate of program participants. Recommendations from Office of National Drug Control Policy in the White House conclude that "the longer he [the drug abuser] remains in treatment, the more likely it is that drug dependency can be reduced or ended altogether."[54] The Institute of Medicine found that for virtually every treatment modality, the longer the treatment, the better the outcome.

Although policymakers agree that longer term treatment should be encouraged, they fail to recognize how the heterogeneity of the existing system undermines their efforts. Under existing pluralistic arrangements, responsibility is divided, diffused, and obscured. This reduces the incentive to extend treatment duration because key decisionmakers are not currently held accountable for the outcomes that longer treatment will improve. The benefits of prolonged treatment are diffused throughout society, while the costs are borne by particular programs or employers. Those who are administering or paying for treatment thus have little to gain by prolonging episodes of treatment. In fact, by some of the criteria that are now used to judge their performance, prolonging treatment may make their efforts appear less successful.

Consider the administrator of a government-funded treatment program that is one of several in a local community. To continue to receive grants, the program must be judged successful by government officials. But "success" is rarely if ever measured in terms of client outcomes: virtually all outcomes-related data requirements were eliminated under the provisions of the ADMS block grant. And even if the program did improve outcomes by retaining its clients, the resulting benefits to the community (increased productivity, reduced crime) would not necessarily be attributed to this program, which is one of several treating drug abuse. There are thus no "rewards" for keeping clients in treatment. In fact, the only available measures that are program-specific are related to process; most commonly, how many clients are treated. Consequently, if administrators devote more resources to retaining or successfully treating clients, they not only do not gain credit for improved community well-being, they are likely to be penalized because they appear to be doing too little (that

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is, treating too few clients) with the money that the government has provided to them.

Consider the administrator of a health insurance program for a large business. Paying for longer episodes of treatment would likely increase the number of drug abusing employees who could return to full functioning. Since most workers change jobs every few years, however, the company would be paying an extended cost though much of the benefits would be reaped by future employers. Extended treatment would also mean paying more for drug treatment for the adolescents covered under their parents' insurance. This benefits the employer only in the most tangential manner, by reducing parents' worries about their family and perhaps thus enhancing their productivity. In addition, extended treatment could make it more difficult for employers to fire workers who continued to abuse drugs, but were still nominally in treatment. In short, the benefits to the employer of prolonged treatment are modest relative to the additional costs.[55]

Because there exists a publicly funded treatment system, employers can rationalize short-term treatment as "doing their share." Clients requiring more extended treatment are viewed as the appropriate responsibility of the public sector. It is thus not surprising that private insurance covers most extensively short-term detoxification, although research suggests this is of questionable efficacy.[56] In recent years, private insurers have focused on further reducing the duration of the treatment they cover through a variety of utilization management techniques.

Under these conditions, even when insurance coverage of substance abuse is required by state law, the employer will likely be allowed to offer minimally adequate benefits. Because there are currently so many different modes and methods of treatment, it is difficult for policymakers to argue that the shortest (and cheapest) duration of treatment is any less acceptable than more prolonged treatment. Indeed, the more drug treatment is labeled a medical condition, the stronger the tendency there is to treat it like other medical conditions, for which private insurers and public programs are emphasizing shorter rather than longer episodes of treatment.

A second aspect of the link between stocks and flows involves the admissions practices of treatment providers. In early incarnations of the treatment system, most capacity was accessible to all who sought

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admission. Prison-based programs were available to criminals and noncriminals alike. Residential treatment programs were supported almost entirely by government grants, which required open admissions policies. Self-help groups typically had strong philosophies of inclusion, defining group membership by the shared problem of substance abuse. Virtually all these programs embodied at least in part a philosophy of changing the values of participants and enhancing societal well-being.

The expansion of community-based treatment in the early 1970s and nonspecialized providers in the early 1980s changed the type of providers in the drug treatment field. These new providers had different motivations, which significantly affected the accessibility of existing capacity. Over this period, the role of for-profit agencies expanded significantly. Virtually nonexistent in the 1960s, proprietary agencies provided 20 percent of all treatment by the mid-1980s. In addition, a significant number of nonprofit nonspecialized agencies, such as community hospitals, established chemical dependency programs. These nonspecialized nonprofit providers currently represent a significant share of both inpatient and outpatient treatment.

These newly entering agencies saw drug treatment as a business, not a mission of social improvement.[57] For-profit agencies had entered the field to make a profit. The private nonprofit agencies that added drug treatment programs generally did not see them as fundamental to their basic mission. Drug treatment was intended to fill empty beds or generate more revenue, with profits being used to subsidize other higher priority services. For either type of provider, the goal for the drug treatment program was to maximize profits or surplus.

Accompanying this "privatization" of provider motives was a change in explicit and implicit admissions policies. These agencies would seek profitable patients and avoid those who were unprofitable, either because they were unusually expensive to treat or lacked the funding to pay adequately for their treatment.[58] Consequently, private programs often operate with only a fraction of their capacity being used, even in areas where the publicly-funded programs are at full capacity and maintaining waiting lists.[59] It may be more profitable for private programs to carry empty beds or under-used personnel, rather than admit patients whose treatment is inadequately reimbursed or who might be disruptive and drive away more

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lucrative clientele. This is reflected in agencies' policies towards potential clients enrolled in Medicaid. (Medicaid is the primary public insurance program for low-income Americans, but often reimburses services at very low rates.) Of the agencies surveyed on the DASRS in 1990, a quarter refused to take any clients covered by Medicaid.

Consequently, capacity in a community is not always accessible to all who live there. The larger the proportion of services in a community that are provided by for-profit or nonspecialized non-profit agencies, the greater a problem this is likely to be. While this implication of a fragmented treatment system has been identified in previous proposals for reform, a less direct but potentially more problematic implication has been overlooked. The selective accessibility of privatized treatment capacity can significantly undermine the viability of the publicly financed treatment system that operates alongside it.

In its 1990 report, the Institute of Medicine expressed concern about the dwindling funding of drug treatment agencies serving publicly funded clients. It noted that funding per client had declined from the late 1970s through the 1980s and suggested that "the most sensible course is to increase public resources to restore earlier levels of service intensity, facility quality, and staff skills."[60] What was missed was the link between this decline in the quality of the publicly financed treatment system and the simultaneous expansion in the privatized portion of the treatment system.

As privately oriented agencies become established, they selectively enroll clients who are best able to pay for services. Thus most privately insured clients are treated in these settings. Data from NDATUS reveal that in 1987, 60 percent of the clientele of for-profit programs were covered by private insurance, compared to 18 percent of the clientele of other programs. Because private insurance plans pay more generously than Medicaid or government grants, these clients provide the greatest revenue to the agency. As they are funneled away from the public sector, so too are these financial resources. With private insurance coverage largely limited to short-term treatment, the clients that reach the public sector are those who have such serious drug dependencies that they have exhausted their insurance coverage.

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In the longer term, the bifurcation of the treatment system into public and private sectors undermines public support for the former. Privately insured clients tend to be better educated, to have greater financial resources, and to be better connected to systems of social support than are others seeking treatment. In short, these are the clients with the most effective political voice. As they are diverted from the publicly financed to the privately financed treatment system, support for government financing for drug treatment is likely to decline. (This argument is analogous to concerns that when the most politically articulate households enroll their children in private schools, support for adequate funding of public education diminishes.)

This situation is exacerbated by a second form of selective admission. Privatized facilities can be expected to avoid the most difficult and costly clients, both because they may in themselves be unprofitable to treat and because their presence may drive away other more profitable patients. As the privatized facilities screen out the most costly clients, they are "dumped" on publicly funded programs that are required to have open admissions policies. This further drains the resources of these programs. Providers in these settings will therefore have little incentive to try to keep these most difficult clients in treatment, leading to high drop-out rates. With more limited revenues and more expensive patients than their private sector counterparts, publicly funded programs will inevitably appear less effective than they otherwise would have. This seemingly poor performance will then add to Americans' disenchantment with government. It further undermines the political support for spending tax dollars on drug treatment. As government funding drops, the quality of treatment in this part of the system declines still further and the cycle continues.

It is thus not coincidental that the quality of government-funded drug treatment has declined at the very time that the treatment system has become more privatized. In a system divided between public and private, when only the latter programs are able to select the clients they treat, the groundwork is set for an ever-declining downward spiral in the effectiveness of publicly-funded treatment and in popular support for that treatment. Proposals to restore the public system to its previous levels of funding and quality will simply

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be ignored unless a way is also found to restore the base of popular support for this funding.

*The Incapacity of Remedial Measures*

A final implication of the fragmented drug treatment system involves the effectiveness of government efforts to expand capacity in particular geographic areas or for particular groups of clients. Although there is a broad public consensus that drug abuse represents a serious national problem, there are considerable differences of opinion about whether that problem is better addressed through more drug treatment or more jails. With virtually no federal standards or state guidelines, the treatment capacity in each community is largely the result of decisions made by that community. This reflects in part a willingness to spend local funds on treatment programs, in part a willingness to work to overcome neighborhood opposition to siting new treatment programs in their "backyards."

Because communities differ in their attitudes toward these issues, it is not surprising to find considerable local variation in treatment capacity. New York City has the greatest capacity, with approximately 775 treatment slots per 100,000 residents. Other large cities, including Washington D.C., Philadelphia, Boston, and San Francisco, have capacity ranging from 275 to 400 slots per 100,000 residents. At the other extreme are cities such as St. Louis, Houston, Baltimore, and Pittsburgh, all of which have less than 150 treatment slots per 100,000 residents. Although there may be some differences in the extent of drug abuse and thus the need for treatment among these cities, those cities in the latter category almost certainly have capacity far too inadequate for their needs.

Attempts by the federal government to reduce these geographic inequities are hampered by the fragmented nature of the treatment system. We have observed that the treatment system is divided between specialized and nonspecialized providers. The latter represent 80 percent of the inpatient treatment capacity and 40 percent of the outpatient capacity (not counting the role of private practitioners).

As noted above, the proportion of the treatment system under the auspices of nonspecialized providers varies considerably from one community to another. Our research suggests that this variation follows a clear pattern.[61] In communities where a limited amount of

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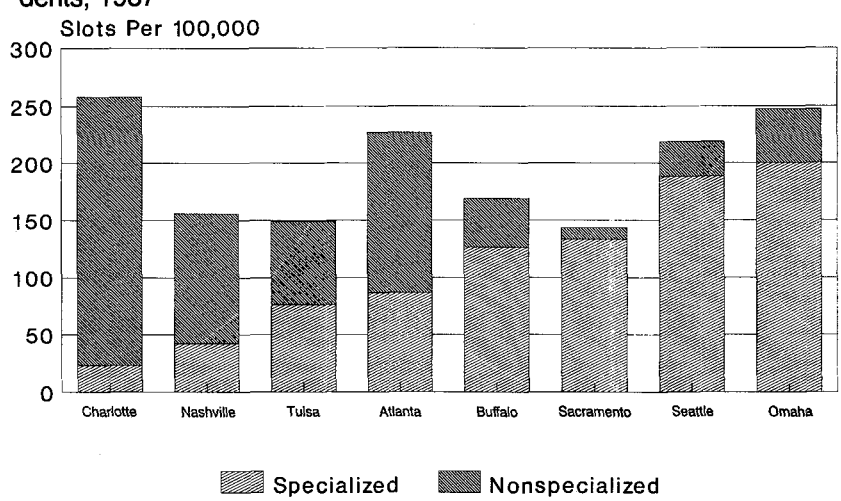
specialized capacity has been supported by government, nonspecialized providers are more likely to go into the drug treatment field. The nonspecialized providers are simply responding to market forces. Where there is significant unmet demand, they enter the market. Where specialized capacity is more nearly adequate to the needs of the community, they look elsewhere for more profitable lines of business.

This pattern is reflected in *Figure 2* for eight moderate-sized cities, chosen to be geographically representative of the United States. For each city, we have plotted the treatment capacity per 100,000 residents in specialized and nonspecialized settings. In the cities that had a more fully developed network of specialized treatment capacity (Sacramento, Buffalo, Seattle, and Omaha), the role of nonspecialized providers is relatively modest. Nonspecialized providers delivered on average just over 15 percent of all drug treatment in these communities. For those cities with limited specialized capacity (Tulsa, Nashville, Atlanta, and Charlotte), nonspecialized providers averaged over 70 percent of total treatment capacity.[62]

Figure 2. Specialized vs. Nonspecialized Capacity Per 100,000 Residents, 1987




Specialized and nonspecialized capacity can thus be seen at least to some extent as substitutes for one another. This holds some important implications for government policies to expand capacity. Additional government funding will tend to expand capacity in specialized

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settings. But as this capacity expands, capacity in nonspecialized settings will decline as these providers shift out of the drug treatment field into other more profitable ventures. Even though government has targeted more resources to drug treatment in that community, aggregate capacity (counting both specialized and nonspecialized providers) may increase by much less than would otherwise have been expected. Indeed, if nonspecialized providers cut back at the same rate that specialized providers expand, aggregate capacity may be no higher at all despite the additional government spending.

Faced with short-run "crises," policymakers often reallocate resources in an effort to expand capacity where it is most needed. For example, in light of recent data on the increase in emergency room admissions related to cocaine and heroin use, the Secretary of the Department of Health and Human Services announced that the agency was diverting funds to the half dozen worst-off cities to increase their treatment capacity.[63] If there are substantial offsetting declines in nonspecialized capacity, this reallocation may yield only modest benefits because it leads to only modest increases in total capacity.[64] These offsetting effects are likely to be largest in communities where nonspecialized capacity represents a large share of all treatment. But these are exactly the communities that policymakers are likely to target, since the nonspecialized facilities are undercounted in official statistics, making these cities appear to have too little capacity. As a result, federal funding targeted to expand specialized capacity will go most often to those communities in which it is most likely to be offset by reductions in nonspecialized capacity.

Because most nonspecialized facilities are financed and operated by private interests, policymakers have little direct influence over these offsetting reductions in capacity. Their only potentially effective response is to alter the nature of publicly funded treatment. If this treatment can be made to appear sufficiently undesirable to private paying clients, then it can be expanded without attracting those already being treated in nonspecialized settings.[65] This means deliberately keeping the treatment that is financed by government less attractive to clients. This discourages substitution from the privatized sector, but at the cost of also discouraging those who should be treated in the public sector and possibly worsening the outcomes for those who are treated under government auspices. Here again, the

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coexistence of public and private sectors undermines the performance of the public portion of the treatment system.

## TOWARD A NEW NATIONAL STRATEGY FOR TREATING SUBSTANCE ABUSE

We are four years and one presidential term into the latest war on drugs in the United States. The successes of this collective effort, such as they are, are reflected primarily in changing popular attitudes about the acceptability of certain illicit substances, and thus in a decline in experimental drug use among adolescents. On the treatment front, every piece of solid evidence suggests that we are losing ground. The treatment system has been largely ineffective at reducing the prevalence of drug dependence or its societal costs. It has been slow to adapt to newly emerging problems. And, we have suggested here, these inadequacies are inextricably linked to the fragmented structure and goals of the existing treatment system.

Yet policymakers continue to favor this fragmented approach. When "an alternative drug strategy" is proposed in Washington, it takes the form of spending more money on drug treatment, not rethinking the way in which treatment is financed and delivered.[66] The national drug strategy reports from the White House annually applaud the division of responsibility between state and federal government, public and private sectors. These reports, as well as the one from the Institute of Medicine, recommend expanding the role of private insurance coverage for drug treatment to operate side-by-side with the publicly funded system. In our assessment, this continued support reflects in part a failure to understand the inconsistencies that are inherent in current public policies,[67] in part a failure of vision, an inability to find an alternative conceptual framework that would legitimize a different type of policy-making. Policymakers thus continue to endorse implicitly a system that often works in direct opposition to the goals that they espouse.

Not all the failings of the treatment system can or should be linked to its fragmented state. Substance abuse is a daunting problem for both individuals and society. Many who abuse substances enter treatment only reluctantly and half-heartedly. Even those who are strongly motivated may find it difficult to deal with their addiction and may require repeated episodes of treatment to control their drug

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use. To some observers, treatment will therefore always appear a relatively inefficient way of addressing drug-related societal problems. Nonetheless, it is worth asking if there is not a more sensible way to organize our nation's approach to this problem.

To this end, it's illustrative to return to military analogies. Although likening treatment to waging war may strain the metaphor, it is striking how peculiar America's current approach to drug treatment appears from this perspective.[68] We would have been deeply distressed to learn that commanders in the Persian Gulf were unable to keep track of a quarter of their forces. Yet government statistics overlook this much of the treatment system for substance abuse. We would have seriously questioned a military chain of command that gave local commanders signals that directly opposed the goals stated by the high command. Yet we accept a drug treatment system in which the incentives for decisionmakers at the local level, such as those encouraging short-term treatment, contradict and undermine national goals. We would have been puzzled if field commanders refused certain missions. Yet we accept a treatment system in which many providers can and do avoid clients with the most difficult problems. We would have been appalled if reports from the front showed that when some military units advanced, others decided to withdraw. Yet we have a treatment system in which government policies that expand some forms of capacity induce other providers to leave the field.

The decentralization, fragmentation, and disorganization that Americans accept in many aspects of their lives are set aside when they face a compelling national crisis. Many Americans believe that drug use falls into this category. This calls for a different strategy for designing a treatment system. One does not, in short, fight a war with market forces. One establishes collective responsibility for the problem and structures a system through which it can be collectively and effectively addressed.

We propose here an approach that follows from this philosophy. It represents a philosophical alternative to the two conceptual models—medical and criminal justice—that have shaped the treatment system in the past. Neither of these models adequately deals with the contemporary problems of drug use or modern methods of treatment. Although the medical model reflects the legitimacy of treating drug abuse as a health problem, it is ill-suited to apply to a chronic

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condition like substance abuse.[69] It treats the problem of drug use as an individual issue and erroneously presumes that patients will be able to initiate treatment when needed. It encourages short-term episodic treatment, rather than the long-term contact required to deal with a condition where clients often relapse. Moreover, the medical model presumes that conditions are diagnosed and treatments selected by professionals operating within reasonably well-defined norms, questionable presumptions in the treatment of substance abuse.

The criminal justice model of treatment places individual drug users in a broader context by holding them to societal norms of behavior. Nonetheless, it remains focused on the individual, who is seen as both the source of the problem and the ultimate source of a solution. It is heavily laden with overtones of drug use as a deviant behavior and thus tends to stigmatize participants. This stigma discourages drug users from seeking treatment. It encourages them to disassociate themselves from the treatment system as quickly as possible, leading to episodic and incomplete treatment of a chronic condition.

But whatever the limitations of each individual model, we suggest here that the greatest problems for policy-making occur when these perspectives coexist within a single system, creating conflicting norms for appropriate treatment and diffusing notions of responsibility. These problems are sufficiently severe that we believe that a national drug treatment strategy must be based on a single consistent philosophy. This philosophy must recast the goals around which we structure the treatment system as well as change the incentives facing key decisionmakers.

The alternative we propose can be termed a "public utility" or "public health" model. It characterizes drug abuse as a collective problem and a collective responsibility. Under this approach, a single provider agency (which might operate out of multiple sites) would be established in each community, analogous to the single power company or water utility that exists in most localities. As with utilities, the participating providers would be required to serve all who applied for service. As with public utilities, this agency could be run by the local government, or a private firm could manage the agency under contract. Under either arrangement, the performance

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of providers would be monitored by local government, which would be accountable for that performance.

All residents in need of treatment would apply through a single intake system, although again this could be administered at multiple sites. They would be given the choice of modality and site of treatment. The system would be financed entirely through federal funds, allocated among communities based on their size and various indirect measures of drug problems (such as drug related emergency room admissions or waiting lists for treatment).

This approach should have several advantages over the current system. Because the entire system would be federally funded, it would reduce existing geographic disparities in willingness or ability to fund drug treatment. Because all treatment would be financed through a single agency, it would be easy to track system capacity. Because a single agency would be responsible for all treatment in the community, there would be a more sharply defined connection between agency performance and community outcomes. This would create incentives for administrators in the agency to be sensitive to some of the more broadly diffused benefits of certain types of treatments. Because all clients would be applying through a single point of entry, unmet demand could be more accurately assessed through the length of a waiting list. Information about treatment efficacy could be more readily collected through this network of providers and disseminated by the federal agency responsible for funding treatment.[70]

Perhaps most fundamentally, this approach would broaden the focus of the treatment system. Under current arrangements, drug treatment is defined almost exclusively in terms of the individual drug user. This is a natural outgrowth of both medical and criminal justice models of treatment. The first defines drug use in terms of individual functional problems, the second in terms of individual moral failings. This individualized approach carries some serious liabilities. Many programs ignore external influences on the drug user. According to statistics collected by NIDA, 20 percent of all treatment programs have no services for "collaterals," the family and friends of drug users. Those that do, serve only small numbers: while there were 144,000 drug users in treatment in October 1987, only 24,000 collaterals were affiliated with these programs.[71]

Perhaps more problematic, in the current system individuals are served only episodically. Apart from mutual assistance groups and

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some therapeutic communities, providers assume responsibility for drug users only so long as they actively participate in the treatment program. Once they leave—with or without having completed the standard course of treatment—few programs actively follow clients, monitor their success at controlling their drug use, or offer supportive services.[72] With most government-funded programs operating near full capacity, there is little incentive for them to seek out additional clients, particularly those who may most need treatment but who would be most challenging and resource-demanding clients.[73] Those providing treatment are rewarded in terms of the numbers they treat, not the outcomes they produce.

The incentives produced by a public utility model would encourage extending the scope of treatment programs. Because one agency was responsible for the drug treatment in a community, bad outcomes, such as high relapse rates, could be clearly linked to failures of the treatment approach. This should encourage greater emphasis on establishing aftercare programs and maintaining continuity of treatment. The single treatment agency could more readily coordinate its efforts with other community-based interventions, including community mental health centers, employment programs and social service agencies. Because the well-being of collaterals has become a major public concern (due in large part to the spread of AIDS in this population), the greater public accountability would encourage more inclusion of the family and friends of drug users. Because there is only a single provider and funding stream, this approach eliminates current incentives to shift costs, problematic clients, and responsibilities from one part of the system to the other. In these ways, the focus of treatment would to some extent be shifted from the individual to the community as a whole.

Despite these advantages, restructuring the drug treatment system in this way could be questioned on several grounds. This proposal consolidates drug treatment into a single system. It eliminates some of the potential for different purchasers, public and private, to choose different types of treatment and thus inhibits some of the competition that is often lauded as a source of innovation in American medicine.[74] But whatever one thinks about the value of competition in medical care generally, there are reasons to doubt that it offers great potential for improving drug treatment. Private insurers have, to date, favored

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treatment modes that policymakers concluded a decade ago were costly and relatively ineffective.

Moreover, existing arrangements often inhibit rather than encourage choice. Individuals covered by private insurance are typically required to seek treatment in a particular modality or facility. Those seeking care under government-financing are unable to gain access to many private facilities. With few sources of information, many potential clients are unaware of the options that they do have in their community. A public utility system such as that proposed here might actually lead to greater choice. Potential clients would have real access to all programs in their communities, which would be required to have open admissions policies. Once admitted to the system, clients could be informed about the full array of treatment programs that had openings. They could thus make a more open and informed choice among different modalities. The advantages of this centralized assessment and information are sufficiently great that the National Drug Strategy reports from the White House—generally a fervent guardian of choice and the free market—have strongly endorsed the notion of a "single point of entry" to the treatment system.

A somewhat more compelling concern involves the extent to which these reforms might undermine popular support for drug treatment. It is sometimes argued that the medical model is an important source of legitimacy for drug treatment. Because drug use is illegal and drug abusers receive little public sympathy, so this reasoning goes, the public will be unwilling to support consistently adequate treatment. Covering treatment under private health insurance mitigates the stigmatizing aspects of drug use.

> Since neither heroin addicts nor the people who care for them have political clout, drug abuse services should be tied to services that enjoy a wider base of support. Like most social services and psychiatric services, drug treatment for the poor has suffered from the public's lack of interest and commitment, even in periods of economic prosperity. . . The obvious answer is that substance abuse services for the poor should be funded by the same insurance mechanisms that cover the rest of medical care.[75]

Although history suggests that public support for drug treatment does wax and wane over time, it is our contention that the combination of public and private funding is exactly the wrong response.

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As we suggested above, a bifurcated system not only runs the risk of dividing and diffusing responsibility, it tends to isolate the least profitable, most difficult clients in the public sector and thus tends to undermine public confidence in that part of the treatment system. This in itself reduces popular willingness to pay for drug treatment. Moreover, the treatment covered under private insurance is often inappropriate for the chronic needs of most drug abusers.

A clearly separate system of drug treatment does run the risk of becoming stigmatized. This risk would be reduced if treatment programs were geographically colocated with other community-based services, as suggested earlier. Still, given the modest success rates of most treatment programs, the American public could decide that treatment is a poor investment. But we think that either outcome is less likely when the scope of public responsibilities is made clear and when all Americans are treated within a common system. The spread of drug abuse to the middle and upper classes should help to destigmatize this problem and broaden the political base for public funding. Currently, these commonalities are obscured because financially well-off drug users are treated in different, more medicalized, settings than are government-financed clients. A two-track system allows the clients in each track to see themselves, and their drug related problems, as somehow distinct from the other group. When one group is less able to identify with the other, a powerful bond is lost. The risk of stigma for the disenfranchised group becomes much greater. The public utility model should reduce this separation.

This returns us to a broader philosophical point, which can be also set within the metaphor of waging war. In his introduction to von Clausewitz' book, *On War,* Anatol Rapoport suggests that the real impact of war on society comes not from how that war is waged, but from how the war is viewed by society. "The nature of war is itself to a large extent determined by how man conceives of it. . . . We would be well advised to inquire into the way the acceptance or rejection of a particular philosophy of war is likely to influence the role of war in human affairs and so profoundly affect our lives."[76]

So, we would argue, goes the war on drugs. The ways we think about drug treatment legitimize particular organizational arrangements and public policies. By building our strategies for developing the treatment system on medical and criminal justice models, we create a system that treats a fragmented portion of each individual,

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the portion that is deemed unhealthy or deviant. We create a system in which collective responsibility is obscured and collective goals lost. In short, we exacerbate all those aspects of American society that dehumanize those who need public assistance and that make it difficult to define and fulfill a common national purpose. But there exist alternative strategies which offer better prospects, such as the public health/utility model described above. These can reinforce links among Americans concerned about this issue. In so doing, they can produce a more cohesive and effective approach to treating drug abuse, one more responsive to the needs of contemporary American society.

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ENDNOTES

[1]Secretary Sullivan has, in repeated public addresses, opposed a government-run insurance system as "unAmerican," hindering competition and innovation and creating a uniform system that "Americans do not need and would not tolerate." See Erick Eckholm, "Rescuing Health Care," *New York Times,* 2 May 1991, A1-B12; Spencer Rich, "Sullivan Proposes Insurers 'Summit' on Medical Insurance," *Washington Post,* 24 September 1991, A7. In 1990, the Bipartisan Commission on Comprehensive Health Care (the "Pepper Commission") rejected a government-run national health insurance plan on the grounds that "movement to a single federal system would eliminate diversity and choice that many believe, appropriately guided, would increase the strength and flexibility of our health care system." US Bipartisan Commission on Comprehensive Health Care, *A Call for Action* (Washington, D.C.: Government Printing Office, 1990), 53.

[2]Drug abuse was ranked tenth most important at the beginning of the decade. See US Department of Justice, *Drug and Crime Facts, 1990,* Office of Justice Programs, Bureau of Justice Statistics, 1991.

[3]Robert Blendon and Karen Donelan, "The 1988 Election: How Important Was Health?" *Health Affairs* (Fall 1989): 6–15.

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[4]OTI was originally a part of the Alcohol, Drug Abuse, and Mental Health Administration, since reconfigured and renamed as the Substance Abuse and Mental Health Administration.

[5]William McAuliffe, "Health Care Policy Issues in the Drug Abuser Treatment Field," *Journal of Health Politics, Policy and Law* 15 (2) (Summer 1990): 357–85; Dean Gerstein and Henrick Harwood, eds., *Treating Drug Problems: Volume I, A Study of the Evolution, Effectiveness and Financing of Public and Private Drug Treatment Systems* (Washington, D.C.: National Academy Press, 1990).

[6]Joseph Treaster, "Hospital Visits Show Abuse of Drugs Is Still on Rise," *New York Times,* 14 May 1992, B1.

[7]See the footnotes below on Congressional intent for various high priority groups of drug users; see Gerstein et al., *Treating Drug Problems: Volume I.*

[8]K.M. Jamieson and T.J. Flanagan, *Sourcebook of Criminal Justice Statistics—1988, US Department of Justice, Office of Justice Programs, 1989, 202.*

[9]Joseph Treaster, "New Drug Chief Turns to Softer Side of Issue," *New York Times,* 15 April 1991, A12.

[10]McAuliffe, 357–85, and Gerstein et al., *Treating Drug Problems: Volume I.*

[11]Treaster, B1; M. Marriot, "For Addicts, a Long, Scary Wait for Treatment," *New York Times,* 10 January 1990, 1; S. Wooton, "Putting Addicts on Hold: In Maryland, Treatment is Elusive, Brief, Often Ineffective," *Baltimore Sun,* 29 April 1990, 1 and 14; US General Accounting Office, *Drug Treatment: Some Clinics Not Meeting Goal of Prompt Treatment for Intravenous Drug Users,* Publication No. GAO/HRD-90–80BR (Washington, D.C.: General Accounting Office, 1990).

[12]Concerns about the spread of Acquired Immune Deficiency Syndrome led Congress to establish standards of timely access for IV-drug users. The Anti-Drug Abuse Act of 1988 required states to provide assurances that IV-drug users would wait no more than seven days for admission to a program, "to the maximum extent practicable." But this requirement has been incompletely enforced. See US General Accounting Office, *Drug Treatment: Some Clinics Not Meeting Goal of Prompt Treatment for Intravenous Drug Users.*

[13]Mark Schlesinger, Robert Dorwart, and Robin Clark, "Treatment Capacity for Drug Problems in the United States: Public Policy in a Fragmented Service System," in *Background Papers on Drug Abuse Financing and Services Research,* Drug Abuse Services Research Series Number 1 (Rockville, Md.: Alcohol, Drug Abuse and Mental Health Administration, 1991), 16–57.

[14]Constance Horgan, Margo Rosenbach, Ellen Otsby, and Barbara Butrica, "Targeting Special Populations With Drug Abuse Problems: Pregnant Women," in *Background Papers on Drug Abuse Financing and Services Research,* Drug Abuse Services Research Series Number 1 (Rockville, Md.: Alcohol, Drug Abuse and Mental Health Administration, 1991), 123–42.

[15]US General Accounting Office, *Drug Exposed Infants: A Generation At Risk,* GAO/HRD-90–38 (Washington, D.C.: General Accounting Office, 28 June 1990).

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[16]David Courtwright, "A Century of American Narcotic Policy," in Dean Gerstein and Henrick Harwood, eds., *Treating Drug Problems: Volume II, Commissioned Papers on Historical, Institutional and Economic Contexts of Drug Treatment* (Washington, D.C.: National Academy Press, 1992), 1–62; Gerstein et al., *Treating Drug Problems: Volume I.*

[17]Gerstein et al., *Treating Drug Problems: Volume I.*

[18]Throughout the rest of this paper, we use the term "substance abuse" to include abuse of both alcohol and illicit drugs. "Drug abuse" will refer exclusively to drugs whose use is currently illegal. In the treatment system, these two categorizations have considerable overlap. On average, half the clients with a drug abuse problem also have problems of alcohol abuse. See Lee Robins and Darrel Regier, eds., *Psychiatric Disorders in America: The Epidemiologic Catchment Area Study* (New York: The Free Press, 1991). Most provider agencies that treat substance abuse also treat alcohol abuse. The treatment methods are often quite similar.

[19]Karst Besteman, "Federal Leadership in Building the National Drug Treatment System," in D. Gerstein and H. Harwood, eds., *Treating Drug Problems, Volume II,* 63–88.

[20]McAuliffe, 357–85; Gerstein et al., *Treating Drug Problems: Volume I.*

[21]Jerome Jaffe, "Reminiscences of a Drug Czar," in W.R. Martin and J. Isbell, eds., *Drug Addiction and the U.S. Public Health Services,* DHEW Publication No. ADM 77–4343 (Washington, D.C.: Government Printing Office, 1978).

[22]Karst Besteman, "Federal Leadership in Building the National Drug Treatment System," in Gerstein et al., *Treating Drug Problems, Volume II,* 63–88.

[23]Frank McArdle, "The Pressure for New Legislated Mandates," in *Government Mandating of Employee Benefits* (Washington, D.C.: Employee Benefit Research Institute, 1987), xxv-xxxv. By the mid-1980s, mandated benefits were less popular, in part because insurers complained that they were raising the cost of premiums beyond the ability of individuals to pay, in part because federal legislation (the Employee Retirement Income Security Act) allowed companies to "self-insure" and become exempt from these state insurance regulations.

[24]T. McGuire and J. Montgomery, "Mandated Mental Health Benefits in Private Health Insurance Policies," *Journal of Health Politics, Policy and Law* 7 (2) (1982): 380–406.

[25]McAuliffe, 357–85.

[26]Michael Morrisey and Gail Jensen, "Employer-Sponsored Insurance Coverage for Alcoholism and Drug-Abuse Treatments," *Journal of Studies in Alcoholism* 49 (1988): 456–61.

[27]McAuliffe, 357–85.

[28]By the end of the 1980s, eighteen states required that private insurers offer coverage for drug and alcohol treatment. See Gerstein et al., *Treating Drug Problems: Volume I.*

[29]P. Scheidemandel, *The Coverage Catalogue,* second edition, (Washington, D.C.: American Psychiatric Association, 1989).

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[30]Calculated from unpublished statistics from the National Drug and Alcohol Treatment Unit Survey.

[31]J.C. Gfroerer, E.H. Adams, and M. Moien, "Drug Abuse Discharges from Non-federal Short-stay Hospitals," *American Journal of Public Health* 78 (1988): 1559–62.

[32]The Institute of Medicine, in contrast, argued that the latter 1980s represented a shift *away* from the medical model toward the criminal justice perspective. See Gerstein et al., *Treating Drug Problems: Volume I,* 43. This apparent difference results from having framed the question somewhat differently than we have in this paper. The IOM report was describing "governing ideas about drugs." The shift toward a criminal justice perspective is evident in the relative proportion of federal funds going to drug interdiction and incarceration, compared to drug treatment. But *within* the treatment system, the focus of this paper is that the medical model gained greater importance.

[33]Cynthia Wallace, "Cocaine Addicts Seeking Care at Hospitals and Other Facilities," *Modern Healthcare* 15 (1985): 58.

[34]David Rochefort and B.M. Logan, "The Alcohol, Drug Abuse, and Mental Health Block Grant: Origins, Design, and Impact," in D. Rochefort, ed., *Handbook on Mental Health Policy in the United States* (New York: Greenwood Press, 1989), 144.

[35]Robert Newcomer and Susan Stoddart, *Review and Evaluation of Alcohol, Drug Abuse and Mental Health Services Block Grant Allotment Formulas,* Final Report, Contract No. 282–85–0061 (Rockville, Md.: Alcohol, Drug Abuse and Mental Health Administration, 1986).

[36]Thomas McGuire, Christopher Ruhm, and Barbara Shatkin, "Defining the Public Interest in Workplace Drug Abuse Policy," *Background Papers on Drug Abuse Financing and Services Research,* Drug Abuse Services Research Series Number 1 (Rockville, Md.: Alcohol, Drug Abuse and Mental Health Administration, 1991), 107–22; Larson, Ph.D. Thesis.

[37]Gerstein et al., *Treating Drug Problems: Volume I.*

[38]The exact count of prisoners "under treatment" varies considerably from one source to another, in large part due to ambiguities in what constitutes "treatment." Estimates of inmates in state facilities under treatment range from 6.2 to 11.1 percent, representing between 29,000 and 52,000 prisoners. See K. Jamieson and T. Flanagan, *Sourcebook of Criminal Justice Statistics—1988,* US Department of Justice, Office of Justice Programs, 1989; M. Chaiken. *In-prison Programs for Drug-involved Offenders,* Department of Justice, Office of Justice Programs, Publication No. NCJ 117999, 1989. NIDA surveys indicate that there are about 50,000 treatment slots in residential programs, which operate at about 80 percent capacity.

[39]Gerstein et al., *Treating Drug Problems: Volume I;* McAuliffe, 357–85; H.T. Yhar, "A National Comparison of Public and Private-Sector Alcoholism Treatment Delivery System Characteristics," *Journal of Studies in Alcoholism* 49 (1988): 233–39.

[40]Schlesinger et al., 16–57; Gerstein et al., *Treating Drug Problems: Volume I.*

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[41]Schlesinger et al., 16–57.

[42]See annual reports by National Council of Community Mental Health Centers, *Membership Profile Report,* NCCMHC (Rockville, Md.: April 1985, 1986, 1987).

[43]For data on private institutions, see National Association of Private Psychiatric Hospitals, *1988 Annual Survey of The National Association of Private Psychiatric Hospitals,* NAPPH, (Washington, D.C.: 1989). For data on state hospitals, see Ronald Manderscheid and Mary Anne Sonnenschein, eds., *Mental Health, United States, 1990,* DHHS Publication No. (ADM) 90–1708 (Rockville, Md.: Alcohol, Drug Abuse and Mental Health Administration, 1990).

[44]Data from community general hospitals can be found in Dorothy Rice and Sanford Kelman, "Measuring Comorbidity and Overlap in the Hospitalization Cost for Alcohol and Drug Abuse and Mental Illness," *Inquiry* 26 (1989): 249–60. Data on hospitalizations in Veterans Affairs hospitals is from R. Rosenheck, L. Massari, and B. Astrachan, "The Impact of DRG-based Budgeting on Inpatient Psychiatric Care in Veterans Administration Medical Centers," *Medical Care* 28 (1990): 124–34.

[45]Because the data from a number of surveys does not distinguish between alcohol and drug abuse, we can construct more comprehensive estimates of the missing portions of the treatment system by considering together the two forms of substance abuse.

[46]Data from the Epidemiologic Catchment Area study found that among those diagnosed as having drug abuse or dependence, 20 percent also were diagnosed as having a major depression, 23 percent as having phobic disorders, and a significant additional number as having other major psychiatric problems. See Lee Robins and Darrel Regier, eds., *Psychiatric Disorders in America: The Epidemiologic Catchment Area Study.* See also V. Brown, "The Dual Crisis: Mental Illness and Substance Abuse," *American Psychologist* 44 (1989): 565–69.

[47]David Mechanic, "General Physicians' Limited Role in Mental Health Care," *Hospital and Community Psychiatry* 43 (5) (May 1992): 429.

[48]These estimates are based on our own calculations from unpublished federal data. Counting both specialized and nonspecialized capacity, San Jose has 493 treatment slots per 100,000 residents; San Antonio has 565. If one counts only specialized capacity, however, the two cities have 123 and 169 treatment slots per hundred thousand, respectively. By comparison, Seattle has 219 slots per hundred thousand residents (189 in specialized capacity) and Detroit has 209 (176 in specialized capacity).

[49]Gerstein et al., *Treating Drug Problems: Volume I,* 23.

[50]Schlesinger et al., 16–57.

[51]Ibid.

[52]Leonard Saxe and Gila Shusterman, "Drug Treatment Modalities: A Taxonomy to Aid Development of Services Research," in *Background Papers on Drug Abuse Financing and Services Research,* Drug Abuse Services Research Series Number 1, 1–15; Robert Apsler and Wayne Harding, "Cost-effectiveness Analysis of Drug Abuse Treatment: Current Status and Recommendations for Future Research," in

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*Background Papers on Drug Abuse Financing and Services Research,* Drug Abuse Services Research Series Number 1, 58–81.

[53]When Veterans Affairs hospitals reduced the average length of stay for veterans hospitalized with diagnoses of substance abuse and mental illness, the fourteen and ninety day readmission rates rose markedly. See R. Rosenheck et al., 124–34. Care should be taken to distinguish this conclusion from a second, seemingly related finding: that clients who stay in a given treatment program for a longer duration have better outcomes than those who drop out of the program earlier. Although this latter result has been thoroughly documented, it does not necessarily suggest that longer duration programs are more effective. It may simply be the case that the most motivated clients stay in their programs, the less motivated drop out.

[54]White House, *National Drug Control Strategy* (Washington, D.C.: Government Printing Office, 1989), 36.

[55]The discussion in the text presents a rather simplified view of a complex process through which workplace benefits are determined, reflecting a bargaining between employers and employees. In some circumstances, drug treatment might prove advantageous to the employer. This might be true if, for example, employees helped through treatment are restored to their former productivity and, out of loyalty to the employer who had helped them through their difficulties, were more likely to stay with the firm over time. But there are many circumstances where the benefits bargained between employers and employees would differ from the optimal benefits viewed from the standpoint of society as a whole. See McGuire et al., 107–22.

[56]Gerstein et al., *Treating Drug Problems: Volume I,* 29.

[57]This was reflected in their treatment practices. For-profit methadone agencies, for example, would often provide the methadone with limited ancillary counseling. The "business" in this case was delivering the methadone; encouraging clients to give up drugs through counseling might benefit society, but it would actually disrupt business. Reflecting this philosophy, some in the field have labeled these programs as "dosing for dollars." See McAuliffe, 357–85.

[58]Richard Steinberg, "The Market for Drug Treatment," in D. Gerstein and H. Harwood, eds., *Treating Drug Problems, Volume II,* 245–88. For a discussion of a similar phenomenon in the psychiatric hospital industry, see Robert Dorwart and Mark Schlesinger, "Privatization of Psychiatric Services," *American Journal of Psychiatry* 145 (1988): 543–53.

[59]Gerstein et al., *Treating Drug Problems: Volume I.*

[60]Ibid., 22.

[61]Schlesinger et al., 16–57.

[62]Comparisons of this sort presume that the need for drug treatment is roughly comparable in these eight cities, so that the cities with more limited specialized capacity had higher levels of unmet need. These specific cities were selected because they were roughly comparable to one another in terms of the number of drug-related arrests and drug-related medical incidents (emergency room admis-

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sions and medical examiner reports of drug-related deaths) that had occurred in the year immediately preceding that in which the data on capacity were collected.

[63]Joseph Treaster, "Hospital Visits Show Abuse of Drugs Is Still on Rise," *New York Times,* 14 May 1992, B1.

[64]It's important to note, however, that if specialized agencies have more open admission policies than do their nonspecialized counterparts, a shift in the composition of capacity may lead to significant improvements in accessibility for the drug users who would otherwise have been denied admission to more privatized programs. Since some specialized providers may use selective admissions policies, however, the extent of these benefits are difficult to predict.

[65]For a related argument on why government officials favor low quality public housing, see Al Nichols and Richard Zeckhauser, "Targeting Transfers Through Restrictions on Recipients," *American Economic Review* 72 (2) (May 1982): 372–77.

[66]For example, a recent report by a task force headed by John Conyers, a Democratic representative from Michigan, and Michael Deaver, a former assistant to President Reagan, "proposed an alternative drug strategy that would boost prevention and treatment efforts rather than law enforcement." See Carolyn Skomeck, "Alternative Drug War Strategy Proposed," *Wisconsin State Journal* (S1) (5 June 1992): 3. The task force did criticize existing policies for overemphasizing the criminal justice model at the expense of the medical model and for ignoring heavy drug users.

[67]For example, both the White House and Institute of Medicine reports favor treating drug abuse as a chronic illness. In the 1989 National Drug Strategy Report, drug use is referred to as being "like other chronic diseases." See White House, *National Drug Control Strategy,* (Washington, D.C.: Government Printing Office, 1989), 36. The Institute of Medicine recommended that provisions for coverage of drug treatment under private insurance should "be similar to provisions for treatment of other chronic, relapsing health problems." See Gerstein et al., *Treating Drug Problems: Volume I,* 31. This characterization of drug abuse seriously undercuts the arguments for private insurance coverage, since virtually all private insurance plans exclude chronic conditions, such as chronic mental illness, from any coverage at all. See Mark Schlesinger, "On the Limits of Expanding Health Care Reform: Chronic Care in Prepaid Settings," *Milbank Memorial Fund Quarterly* 64 (1986): 189–215.

[68]See also Mark Kleiman, *Against Excess: Drug Policy for Results* (New York: Basic Books, 1992).

[69]Arthur Caplan, "Is Medical Care the Right Prescription for Chronic Illness?" in S. Sullivan and M. Lewin, eds., *The Economics and Ethics of Long-Term-Care and Disability* (Washington, D.C.: American Enterprise Institute, 1988), 73–89.

[70]A potentially useful model for lessons about this approach involves the health care system maintained by the Department of Veteran Affairs, though each VA district tends to be much larger, both geographically and in terms of the population served, than the community-oriented model described in the text.

[71]National Institute on Drug Abuse, *National Drug and Alcoholism Treatment Unit Survey, 1987,* (Rockville, Md.: US Department of Health and Human Services, 1989).

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[72]McAuliffe, 357–85.

[73]Many larger private employers have established mechanisms for identifying drug abusers through employee assistance programs. See Christopher Tompkins, "Drug Abuse Among Workers and Employee Assistance Programs," in *Background Papers on Drug Abuse Financing and Services Research,* Drug Abuse Services Research Series Number 1, 82–106. Employees may, however, have an incentive to avoid detection, since they would be at greater risk for losing their jobs if their drug use was known.

[74]See the citations in the first footnote.

[75]McAuliffe, 371.

[76]Anatol Rapaport, "Introduction" to Carl von Clausewitz, *On War* (Great Britain: Penguin Books, 1968), 3–12.

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The temptations that people always found, and probably always will find, hardest to resist are sex, money, and power. Drugs and food belong on this list, of course, but rank nowhere near the top. Nevertheless, our "drug problem" could profitably be viewed in terms of a struggle against temptation, which is precisely the way most Americans in the nineteenth century viewed it. Mark Twain was much amused by this spectacle and offered many wise and witty recommendations on the subject. "There are," he characteristically remarked, "several good protections against temptations, but the surest is cowardice." In a more serious mood, he mockingly pondered, "There are people who strictly deprive themselves of each and every eatable, drinkable and smokable which has in any way acquired a shady reputation. They pay this price for health. And health is all they get. How strange it is!" Mark Twain did not live long enough to see something even stranger, namely, the American government's resorting to the use of naked force to impose this idea on people, at home and abroad. Thus, he never saw his fellow Americans electing and deputizing their representatives in Congress to deprive them of satisfying desires from which they could perfectly well have deprived themselves, if that is what they had really wanted to do.

Thomas Szasz
From *Our Right to Drugs: The Case for a Free Market*

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*Patricia G. Erickson*

# Recent Trends in Canadian Drug Policy: The Decline and Resurgence of Prohibitionism

DURING THE ERA OF ALCOHOL PROHIBITION in the United States, industrious Canadians were producers and exporters of this then forbidden drug across the world's longest undefended border.[1] By contrast, in the current illicit drug trade, Canada though sometimes a transshipment point for drugs destined for the United States,[2] is largely a partner in prohibition of illicit substances. Indeed, Canada, given its early legislative efforts in 1908 to control such substances, and its high profile when the first international treaties were signed, may be said to have led the way in forging modern drug prohibition, influencing the United States in its approach.[3] Since then, Canada and the United States have shared an overlapping history in regard to "narcotics."[4]

While this process of reciprocal influence over eight decades has resulted in many similarities, the outcomes have been different. Because levels of illicit drug use and associated problems are much lower in Canada than they are in the United States, Canada provides an interesting case control study for examining the American experience.

Like most industrialized societies, their drug policies have relied heavily on the criminal law to control drug supplies and to punish offenders. The term "prohibitionism" includes the array of laws, criminal justice practices and social evaluations that serve to suppress

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particular forms of drugs, forbidding their use, production, and sale. Most nations have an official policy of prohibiting narcotics; most are signatories of the United Nations treaty, the *Single Convention on Narcotic Drugs*. Yet implementation varies widely, from the ferocious policies of Malaysia and Singapore to the benign ones practiced by the Netherlands. Vigorous enforcement of drug prohibition involves substantial socioeconomic costs and the curtailment of individual personal freedoms. No democratic government can persevere in this approach unless it has wide support in the populace.

In 1986–1987, while the United States launched a newly invigorated drug war, Canada enunciated a very different federal drug strategy. Since repressive responses to illicit drug use had been the hallmark of drug policies in both countries from the early 1900s, this apparent divergence could be seen as an effort by Canada to distance itself from the legacy of its past policies, to forge a new direction. Was Canada's Drug Strategy something more profound than Canadians just saying 'No Thank You' to drugs? The evidence suggests that Canada still has a distance to go if it wishes to distinguish itself from the more unequivocally aggressive American response.

## A LAW ABIDING SOCIETY

A distinctive feature of Canadian society is the generally lower rate of crime and violence, compared to the United States of America.[5] In 1988, the murder rate south of the Canada-US border was more than three times that to the north, and the American robbery rate was over twice that of Canada's.[6] The total number of homicides in all of Canada in 1990 was 656,[7] comparable to that of either Detroit or Washington, D.C. Canada has much stricter gun control laws than the United States, and Canadian police officers were less likely to be killed on duty in the 1980s than in the two preceding decades.[8] American officers involved in drug related investigations have been increasingly at high risk.[9] Nor has Canada's history been marred to any marked degree by assassinations, civil unrest, and other forms of extreme political violence, leading William Kilbourn to refer to Canada as "the peaceable kingdom still."[10]

Anyone who doubts the uniqueness of Canada's culture, values, and identity need look no further than a recent issue of *Dædalus*.[11] Yet, both Canada and the United States resort to substantial punitive

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responses to criminal offenders. While the American incarceration rate is the highest in the world, and Canada's incarceration rate is one-fourth of that, it is still fifth in the world.[12] An increasing proportion of incarcerated Americans are drug offenders; they comprise close to half of all inmates in certain jurisdictions. In 1988, 6 percent of provincial and 11 percent of federal inmates in Canada were imprisoned for offenses against drug laws: approximately 7,000 in total.[13] If Canada no longer permits capital punishment, it provides the most severe sentence available, life imprisonment, for trafficking or importing cannabis, cocaine, heroin, and other "narcotics." Canada's rate of drug offenses (that is, those discovered and recorded by the police) peaked in the 1980–1985 period at nearly 300 per 100,000. The United Nations reported this to be the highest in the world during that period,[14] but it has apparently been surpassed by the United States since then.[15]

Still the use of illicit drugs in the two countries has been very different. Whatever substance or demographic group is considered, Canadian rates are lower.[16] For example, among cocaine users, the highest levels of use in the US population have been reported in the age category, 18 to 25. In 1982, a year of peak use, 18.8 percent of these young adults were reported to have used cocaine. In the province of Ontario, the proportion of the young adult group using cocaine in 1984 was recorded as 7.1 percent. While 6.7 percent of Ontario high school seniors used cocaine in 1985, in the comparable American group, 13.1 percent had done so. Differences are also conspicuous for cannabis. While the most recent student surveys show 27.5 percent of US seniors using the substance in the past year, 21.6 percent of Ontario high school seniors used it in the same period. Nationally, 23.2 percent of all Canadian adults used cannabis at some time in their lives; only 6.5 percent were current users in 1989. Adult levels of cannabis use in the United States have been consistently higher.

While injection drug use, particularly of opiates, is notoriously difficult to determine, the Canadian estimates of an upper limit of about 25,000 users[17] are dwarfed by estimates of at least one million regular injection drug users in the United States.[18] As shown in *Figure 1*, the death rate in Toronto comprising cases in which heroin or cocaine is detected is from one-seventh to one-fourteenth lower than in the comparable American cities, New York and Philadelphia.

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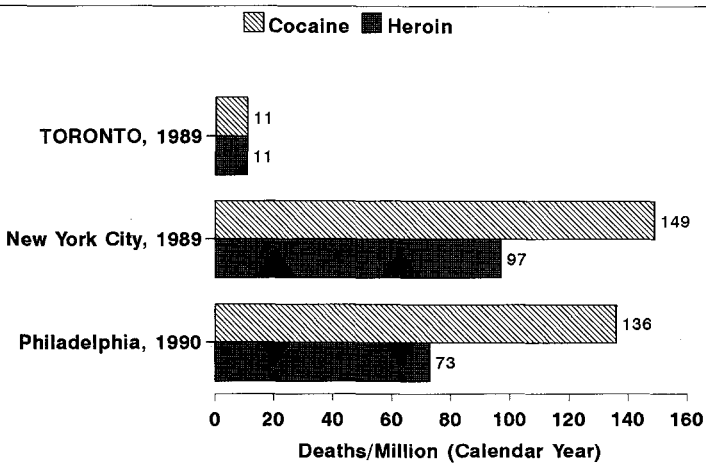
Cases of AIDS and rates of HIV infection attributable to injection drug use as the sole risk factor are also much lower in Canada, at less than 5 percent,[19] though rates are substantially higher in imprisoned populations.[20] The difference may result, at least in part, from the legal availability of needles and syringes in pharmacies in Canada and the introduction of needle exchange programs in major Canadian cities by the end of the 1980s.

Figure 1. Drug-Related Death Rates in Toronto and Selected US Cities




Sorce: Epidemiologic Trends in Drug Abuse. Proceedings, Community Epidemiology Work Group, June, 1991. National Institute on Drug Abuse and Chief Coroner's Office of Ontario.

These differences do not necessarily reflect a more general difference in attitudes to *all* drugs. For example, licit drug use is comparable in the two countries. Per capita alcohol consumption is about the same, with Canada slightly higher; the same is true for cigarette smokers. Also, Canadians appear to be less concerned about illicit drugs than are Americans. When public opinion in both countries was surveyed in 1990 on their most important national problems, Canadians placed drugs eighth on their list; Americans placed it second from the top.[21] National attention in Canada has tended also to focus on issues of tobacco control, the overprescribing of pharmaceuticals, and alcohol problems. The Royal Commission of Inquiry into the Non-Medical Use of Drugs established in 1969 to examine increasing drug use—the Le Dain Commission—may have contributed to this broader perspective when it articulated a definition of "non-medical drug use" that encompassed both licit and illicit substances.[22]

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While the prevalence of illicit drug use is considerably lower in Canada than in the United States and the magnitude of drug use differs substantially, the trends in illicit drug use in both countries have run a parallel course. Both countries experienced a marked rise in illicit drug use during the 1970s, followed by a levelling off, and a decline in the 1980s.[23]

## HISTORY, CULTURE, AND POLICY PERSPECTIVES

There are two major ways of conceptualizing the differences in crime and illicit drug use as between Canada and the United States.[24] The "cultural lag" model assumes that the differences are only a matter of degree; it is simply a matter of time before Canada reflects the same level of such problem activities as its larger neighbor. This version, particularly popular with media commentators for whom each example of violent crime, drug bust, or cocaine overdose provides *further* evidence that Canada is destined to achieve American levels of urban disorder and decay, is very different from the "distinct society" view which holds that the two countries are fundamentally different in their attitudes, values, culture, and social institutions. These, in turn, are thought to shape the propensities for crime and deviance, including illicit drug use. In this latter view, Canada has traditionally valued social order over individual rights and freedoms, producing a more law-abiding populace, placing greater faith in the discretion of legal authorities. These contrasts are summarized by David Bayley:

> Compared with the U.S., Canada is very fortunate indeed . . . Curiously, though, these striking differences in rates of criminality between Canada and the U.S. are not a source of congratulations among Canadians. Instead, they tend to wring their hands in the belief that Canada must inevitably follow the frightening example of the U.S. They do not pause to consider that there may be differences in socioeconomic structure as well as culture between the two countries that would make this unlikely.[25]

Indeed, the broader social net in Canada—more substantial public support for medical care, public schools, and social services[26]—may have helped reduce levels of poverty and deprivation, and may provide less fertile ground for drug use and crime. If Canadians have

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maintained lower levels of drug use, how is this connected to today's sociolegal responses to drugs and the more recent enunciations of a more vigorous drug policy?

In Canada, antinarcotic criminal laws were initiated in 1908, largely directed at opium smoking among Chinese laborers.[27] Subsequent modifications to the laws provided ever harsher penalties and fewer legal protections for suspected users and sellers.[28] This trajectory persisted until 1969. Then, for the first time, the vigor of the legal response diminished. More changes in the direction of greater leniency were expected in the 1970s, in the wake of the Le Dain Commission. Reform of the drug laws appeared to be an imminent possibility.[29] In the 1980s, however, the use of illicit drugs declined. Marijuana arrest activity and sentence severity diminished in Canada, as it did in the United States, where eleven states decriminalized possession, without refueling a new epidemic of marijuana use.[30] Concomitantly, public interest and political attention to drug issues waned.[31]

By the mid-1980s, however, the process of a qualified retreat from criminalization ended; a resurgence of antidrug sentiment and intensification of legal responses followed. What revived this prohibitionism? What factors contributed to this dramatic shift in social response?

## THE LEGACY OF PROHIBITIONISM: 1908–1969

This era of drug policy, extensively analyzed elsewhere,[32] will be summarized briefly here. Canada may be unique in the extent to which centralized bureaucratic control characterized the formative period of Canadian narcotics law. The federal chief of the Division of Narcotic Control coordinated reports from the federal enforcers (the Royal Canadian Mounted Police [RCMP]) and federal drug prosecutors, guaranteeing that most of their expressed need for greater powers were met legislatively. Because criminal law in Canada is under federal jurisdiction, all legal enactments related to the entire country.

During the heyday of the 1920s, when the fundamental structure was first established, provisions provided for the search of premises and their occupants without warrants, the creation and issuance of blanket search warrants, called writs of assistance, for dwellings, various restrictions on legal appeals, the whipping of the convicted,

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the sentencing of offenders to hard labor, mandatory minimum sentences, and the deportation of convicted aliens, regardless of the length of their domicile in Canada. These harsh provisions, possible because of the depth of anti-Asiatic sentiment, were enacted almost solely against the Chinese. Cannabis was added to the schedule in 1923 without parliamentary debate. In 1954, the severity of the penalties for trafficking was increased yet further; the reverse onus of proof, requiring the accused to establish his innocence, was applied to a new offense, possession for the purpose of trafficking.

As P. James Giffen and his colleagues have illustrated in great detail, the principal architects of drug policy in this period were those charged with its execution.[33] This bureaucratic partnership of social control agents remained virtually unchallenged until the 1950s when concern for providing treatment for opiate users broadened the range of players. This was yet further expanded by the marijuana controversy of the 1960s. The public appears to have accepted these broad powers of social control, and the police and courts used them effectively to process drug offenders in substantial numbers, resulting in high rates of criminalization and incarceration.

A reliance on strict enforcement and punishment has traditionally been Canada's primary strategy on illicit drugs. As the Le Dain Commission stated in 1972: "The law is the primary instrument of social policy. . . The question is whether, and to what extent, the criminal law is a proper instrument for such a policy."[34] The Commissioners addressed this question by conducting a cost-benefit analysis with the not unreasonable assumptions (though rarely applied historically in drug policy matters) that the benefits of the policy should be demonstrable, not to be exceeded by its costs.

## THE DECLINE OF PROHIBITIONISM: PENALTY REDUCTION AND MILD LIBERALIZATION, 1969–1986

A number of pressures arose in the 1960s, precipitating the questioning and modification of this dominant policy. There was an upsurge in youthful drug use, especially marijuana, and the overloading of the courts with these "cannabis criminals." Limited sentencing options led half of all cannabis possession offenders to be imprisoned, and the emergence of competing interest groups vying for the right to define "the drug problem" changed the picture.[35]

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A different policy emphasis, manifested gradually in both real and contemplated law reform, the eventual reduction in enforcement activity, less severe sentences, and a new public awareness of individual rights of drug users was apparent. Actual legal changes were few compared to the many debated during this period. Major changes included the provision of a "fine only" sentencing option in 1969 as an amendment to the *Narcotic Control Act* and the provision of absolute and conditional discharge alternatives in 1972.[36] Such discharges, providing a finding of guilt but not a conviction, were new to the *Criminal Code.* Other proposals for legal changes were made but never implemented. For example, a major reform that attracted substantial political attention in 1968, 1970, 1974, and 1980, but not approved, was a proposal to move cannabis from the *Narcotic Control Act* to the less restrictive *Food and Drugs Act.*[37]

Declines in sentence severity for cannabis possession during this period, and greater efficiency of the courts in processing these offenders, helped reduce pressure for meaningful law reform.[38] Judges quickly utilized the fine and discharge options; fewer users were jailed. Convictions climbed dramatically in the 1970s for cannabis offenses (of which about 90 percent were for simple possession) to a peak of nearly 44,000 in 1981, but then declined to 22,510 in 1985. During this period, annual convictions for illicit drugs other than cannabis rarely numbered more than 1,000,[39] and Canada's drug policy was directed at, and dominated by, cannabis.

Another manifestation of some tempering of the earlier allegiance to prohibitionism was an increased recognition of individual rights in drug cases. The process began with critiques in the 1970s and culminated in the mid-1980s with the abolition of writs of assistance, the removal of mandatory minimum sentences for importing, and the elimination of the reverse onus clause in cases of possession for the purpose of trafficking. Although passage of the new *Charter of Rights and Freedoms* in 1982 was not prompted specifically by a concern with perceived injustices regarding drug offenders, its effect was to remove some of the procedural disadvantages that had been applied to suspected or accused drug users/sellers, but not to other categories of potential criminals.[40]

Even minor shifts in a well-entrenched social response to a particular form of deviance cannot occur without changes in the social evaluation of the unacceptable behavior.[41] The initial crimi-

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nalization of illicit drugs was made possible by the development of strongly held fact beliefs concerning the pernicious effects of certain drugs, their ability to enslave users, and the evil and immoral qualities of those who distributed them.[42] A number of social influences in the 1960s and 1970s led to the discrediting of the more extreme forms of the "dope fiend" mythology of the earlier era.

One relevant factor was the narrowing of the social distance between drug users and the mainstream of society. Indeed, many in the mainstream gained personal familiarity with illicit drugs, as the use of marijuana, LSD, and cocaine (at a later date) became more prevalent in the adolescent and young adult population. It is difficult to maintain the seriousness of criminal behavior when the activity is engaged in by a substantial proportion of the population, by those in one's own family and social network. As well, these new users of cannabis and other drugs who were going to court in increasing numbers occupied a higher social status than that associated with the heroin addict stereotype. The law was widely assailed for making criminals of middle class youth. Prime Minister Pierre Trudeau, in a session with students in 1977, said: "If you have a joint and you're smoking it for your private pleasure, you shouldn't be hassled."[43] Also, health risks, physical and psychological dependency, and the progression theory of drug escalation (first marijuana, then heroin), were assessed repeatedly in government reports in many countries, and were deemed less serious than previously believed.[44]

Another influence was the contribution made by cost-benefit research to a more objective analysis of the prevailing policy of criminalization. Many studies documented the weakness of the deterrent effect of the law in preventing the initiation or continuation of drug use.[45] Also, increased evidence of the substantial costs of suppression efforts directed at trafficking, and the limited effectiveness of supply-side measures, had their effect.[46] Together, such studies led many to conclude that existing policy could be improved on, even if agreement on the best alternatives remained elusive.[47]

## THE RESURGENCE OF PROHIBITIONISM: FROM MALIGN NEGLECT TO RENEWED REPRESSION, 1986–1992

As the 1980s advanced, most forms of illicit drug use declined; arrests for cannabis decreased, those for cocaine gradually increased; the

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courts continued routinely to process drug cases; the urgency of earlier drug policy debates was replaced by public and political indifference. Canada had, it seemed, learned to live both with drug use and prohibition.[48] Some imagined that illicit drug use, like abortion, gambling, homosexuality, and other previously criminalized acts would follow the cycles of diminished social concern, less intervention, greater toleration.[49]

In 1986, crucial events occurred. First, the American President, Ronald Reagan, declared a new crusade against drugs, stating that "Drugs are menacing our society... there is no moral middle ground." Within two days, Prime Minister Brian Mulroney departed from his prepared text to announce that "Drug abuse has become an epidemic that undermines our economic as well as our social fabric."[50] Bemused Canadian drug professionals and researchers, who knew that the problems had neither worsened nor gone away, were caught by surprise. Many, sought by the media for comment, challenged the Prime Minister's view of an "epidemic"; the more politically adept reiterated the requirement for resources to prevent and treat existing drug problems, *including* alcohol and prescription drugs. Even government officials were caught off guard, as was one high-ranking official in Health and Welfare Canada at that time, who described the events that followed: "when he [the PM] made that statement, then *we* had to make it a *problem*."[51] Thus drug issues returned to the social and political agenda.

In the aftermath of the Prime Minister's remark, events moved rapidly. The Canadian government created a federal drug secretariat, which consulted widely with community groups and agencies, and provided a new national focus on a drug strategy "with objectives of reducing the harm to individuals, families and communities from the abuse of drugs."[52] Formally announced in May 1987, the Strategy projected funding of $210 million over the next five years. The funds were to be unevenly allocated; 70 percent was to go for prevention and treatment; 30 percent for enforcement and control. Pressure from addiction agencies guaranteed that drug abuse comprised not only illicit drugs, but alcohol, licit pharmaceuticals, solvents, and, to a limited extent, tobacco. The new Strategy explicitly recognized the inadequacy of supply efforts; it made its focus the reduction of demand through education of the young, together with provisions for treatment. This initiative at first distanced itself from the American

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"War on [Illicit] Drugs" and its priority of enforcement over both prevention and treatment.[53]

Canada's Drug Strategy, as it is officially known, has now completed its first five year mandate; in 1992 it was renewed for a further five years.[54] It is timely, therefore, to assess its impact, to consider its likely future direction. Because the Strategy did not simply replace all existing policies and programs, and because public beliefs and attitudes towards drugs, and the social evaluations they entail, are a volatile and conflicting mix, the results have been contradictory.

In this period, manifestations of a renewed spirit of prohibitionism included the creation of new offenses and laws. In 1989, Bill C-61 gave the police new powers to seize and the courts to forfeit the assets of arrested drug offenders. Compared to the previous five years, when the antidrug profiteering program garnered only $51 million, $60 million was realized between 1989 and 1992.[55] Another law, Bill C-264, banning the sale of drug paraphernalia, was enacted in 1988.[56] Some prosecutions of "head shop" merchants followed; drug literature, such as the magazine *High Times,* was stopped at the border. The failure of a Canadian athlete to pass drug tests in the 1988 Olympics, and the resultant inquiry, increased public awareness and concern about the ready availability of performance-enhancing drugs.[57] In 1992 steroids were moved up a step in the legislative hierarchy, from Section F of the *Food and Drugs Act* (covering most prescription drugs) to join barbiturates and amphetamines in Section G which provides more severe penalties for trafficking. Thus, the net of criminalization widened to include drug pipes, literature, and steroid dealers; more of the assets of those suspected of profiting from drug selling were confiscated.

Proposals to increase the surveillance and detection of drug users or sellers and to restrict their liberty became more common. Workplace drug testing and zero tolerance at the border were undoubtedly influenced by American example. The Canadian government, announcing drug testing of transport workers in order to match American practices, backtracked after trade unions, the Privacy Commission, and other groups protested.[58] A multinational corporation, Imperial Oil, initiated random drug testing of all employees in "safety sensitive" positions, and made urine testing mandatory for new employees.[59] Challenges to this policy from the Canadian Civil Liberties Association and the unions are now before the courts. A form of zero tolerance, tried by Canadian Customs officials for a

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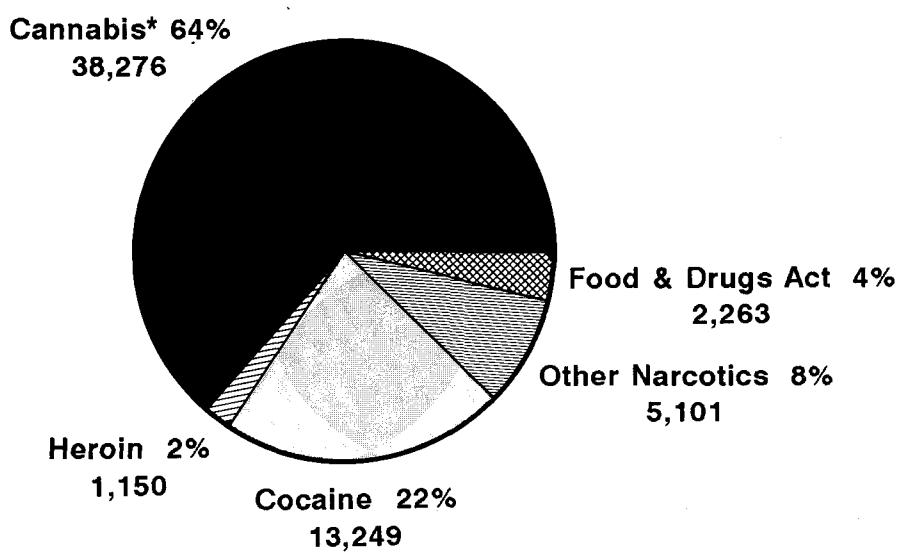
period, was withdrawn after numerous public complaints and little demonstrable payoff in detection. A federal proposal to deny parole to serious violent offenders *and drug traffickers* has aroused little public reaction, to date, and is apparently under active consideration despite the government's commissioned research that showed first-time trafficking offenders were a low risk group for recidivism.[60] Since the *Narcotic Control Act* (1961) already provides life imprisonment for trafficking and importing, calls for tougher penalties must, by definition, either be symbolic or focus on actual sentencing and/or parole practices.[61]

This period of resurgence was marked also by substantial, renewed enforcement and harsher penalties.[62] Cannabis offenses numbered

Figure 2. Drug-Related Offenses by Type of Drug (Canada, 1990)




*Cannabis includes hashish, marijuana, and liquid or oil hashish.
Source: B. Williams, et al., Annual Sourcebook, Canadian Profile, 1992. Toronto: ARF

about 41,000 in 1986 and 38,276 in 1990. Not only did high levels of enforcement continue, but cannabis remained the major component of antidrug activities. In 1990, *Figure 2* shows that 64 percent of the 60,039 drug offenses in Canada were for cannabis; the majority

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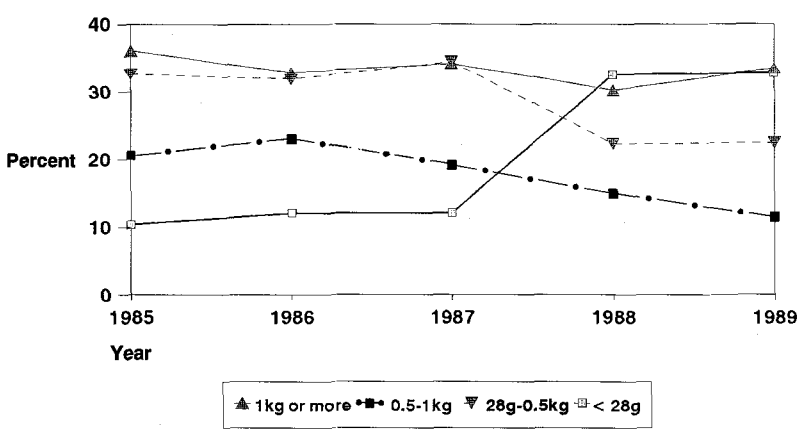
were for simple possession only. Total convictions for cocaine increased from 2,793 to 6,909 between 1985 and 1989, and those incarcerated for cocaine possession went up from 17 percent to 29 percent. Since *convictions* (as opposed to offenses) have not been compiled or published for cannabis since 1985, the reporting of actual conviction totals since that year has been dominated by cocaine, perhaps contributing to the misleading public impression that cannabis was no longer an enforcement priority.

Increased resources were put into local drug squads. In Toronto, for example, ninety-seven new officers were added in 1989, and $1.2 million was spent on drug buys. Enforcement activity was enhanced: seizures doubled; there was a 31 percent increase in all drug charges, a 53 percent rise in trafficking charges.[63] This led to the overloading of court dockets and of jail cells. In Ontario, the number sentenced to provincial correctional facilities for drug offenses rose from 1,812 in 1986–1987 to 3,137 in 1989–1990.[64] This represented an increase from 4 percent to 7 percent of all Ontario incarcerations. Federally, the proportion of inmates admitted under the *Narcotic Control Act* grew from 9 percent to 14 percent between 1986 and 1990.

Figure 3. Cocaine Traffickers Investigated by RCMP, 1985-1989




Source: National Drug Intelligence Estimate, RCMP, 1990.

The nature of federal police activity also changed during the latter half of the 1980s when cannabis and cocaine use were in fact declining or levelling off. The RCMP focused more and more on

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small-scale traffickers. While cocaine trafficking charges more than doubled from 1985–1989,[65] *Figure 3* shows that the proportion of traffickers in the smallest amount (less than one ounce or 28 grams) more than tripled, from 10 percent to 33 percent. At the same time, those investigated for the largest amount (one kilogram or more) declined slightly, while those involving intermediate amounts declined from 53 percent to 34 percent of the total. Although seizures of cocaine were reported to have increased by 268 percent in 1989 (to 712.4 kilograms), this was due principally to a single large seizure of 500 kilograms.

The search for small-scale traffickers was even more pronounced for cannabis. Despite steady declines in use in the population as a whole, and a large drop in seizures, the RCMP maintained an almost equivalent level of charges in 1988 and 1989.[66] As *Figure 4* indicates, from 1985 to 1989 the proportion of traffickers in the smallest amounts nearly tripled, rising from 25 percent to 72 percent, while investigations for the largest amounts decreased from 14 percent to 4 percent of the total.

These data for cocaine and cannabis trafficking illustrate a well-documented phenomenon in the study of crime rates in general, namely that recorded offenses will increase in direct proportion to police resources.[67] This is particularly true when an activity, like drug use and sale, depends on proactive police discovery rather than a citizen-initiated response.[68] Thus, the influx of resources to the police from Canada's Drug Strategy in 1987 enabled the police to demonstrate and maintain a high level of "productivity" in overall investigations, seizures, arrests, and charges. The additional funding was not contingent on the police operating any differently than they were accustomed to doing in drug matters.[69] The overall drug crime rate (offenses per 100,000) climbed from 221.9 in 1986 to 258.9 in 1989.[70] That the police were able to achieve this in a time of stable or declining drug use is a telling testament to their initiative.

Following the advent of the Drug Strategy in 1987, with more government funding for prevention, the police increased their involvement also in community-based alcohol and drug education, with the production of video and other such materials. About 1,000 local officers from 128 forces were trained to deliver these programs by the RCMP's special unit, PACE, Police Assisting Community Programs. In fact, according to the Strategy's own internal assess-

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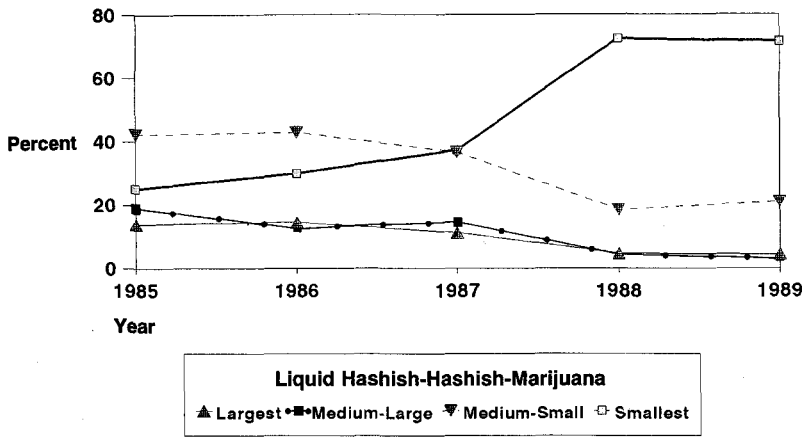
Figure 4. Cannabis Traffickers Investigated by RCMP, 1985-1989




Source: National Drug Intelligence Estimate, RCMP, 1990.

Figure 4a. Categorization of Cannabis Traffickers Investigated by the RCMP

| | |
|---|---|
| Largest: | Marijuana - 1,000 kg or more<br>Hashish - 500 kg or more<br>Liquid Hashish - 50 kg or more |
| Medium-Large: | Marijuana - 100 kg to 1,000 kg<br>Hashish - 50 kg to 500 kg<br>Liquid Hashish - 5 kg to 50 kg |
| Medium-Small: | Marijuana - 10 kg to 100 kg<br>Hashish - 1 kg to 50 kg<br>Liquid Hashish - 0.5 kg to 5 kg |
| Smallest: | Marijuana - Less than 10 kg<br>Hashish - Less than 1 kg<br>Liquid Hashish - Less than 0.5 kg |

Source: National Drug Intelligence Estimate, RCMP, 1990.

ments, the majority of its prevention resources went to police-controlled educational programming.[71]

It is possible that the police officer is indeed the authority figure who can most effectively deliver the abstinence message to youth, urging them to stay away from drugs.[72] The police are perhaps filling a perceived need in the community. Still, the general lack of demonstrated effectiveness in school-based programs in changing actual

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drug use behavior[73] and the lack of systematic evaluation of the police programs,[74] in relation to the variety of needs and experiences of youth, raise doubts. One concern is that preoccupation with illicit drugs diverts attention from the "real killers," alcohol and tobacco.[75] Another worry is that while youthful substance use has declined overall, the proportion of heavier, more frequent users of alcohol, tobacco, and other drugs has not; the "problem" continues.[76] Programs to encompass less risky practices for those already using, or intending to use drugs, or who are experiencing substance-related difficulties, are perhaps not readily delivered by those whose primary role in society is identified with enforcement and punishment.[77] Nor is it at all clear that adequate programs exist to meet Canadian treatment needs when large numbers of Canadians seek alcohol/drug programs in the United States; 3,500 from Ontario alone did so in 1990.[78]

A key social influence that facilitated the renewal of prohibitionism was the image of the drug problem presented to Canadians by the American media.[79] Cocaine, especially in the form of crack, was portrayed as the drug that finally fulfilled all the expectations of the "demon drug" mythology. Represented unidimensionally as highly dangerous and addictive in virtually all popular media sources,[80] the drug scare message was delivered. Although levels of cocaine use and attendant problems undoubtedly increased in Canada during the 1980s, the national survey data indicated that prevalence remained low (current use by 0.9 percent in 1985; 1.4 percent reported use in 1989).[81] The province of Ontario, which has the most consistently recorded trend data, showed a decline in cocaine use in the student population after 1985 and a stable level of use for adults since then.[82] Other Canadian studies showed that most used the drug infrequently and had few serious problems; the headlines told a very different story.[83]

This "secondhand" or "borrowed" drug panic about cocaine and crack was imported from the United States as part of a larger cultural infiltration, with its highly negative evaluations of illicit drug use and users.[84] The feeling of threat helped justify increasingly repressive responses against those defined as the "enemy."[85] Fed by extreme views of "instant addiction," and fatal results followed by exposure to these all-powerful substances, such messages helped to build and

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maintain the consensus required to support the punitive and exclusionary responses to drug users.

Canada and the United States have begun to be less distinguishable in their media and other public imagery concerning drugs. A variety of antidrug messages have appeared on milk cartons, in bus shelters, on letters delivered by the post office, in children's cartoon programs, inserted into sports events on prime-time TV. Ben Johnson, after years of taking steroids and lying about it, returned in disgrace from the Seoul Olympics, repented publicly, and was soon recruited as an antidrug role model for the country's youth.[86] Two people navigated Niagara Falls in a barrel, itself an offense, to show young people that there were alternatives to drugs. Canadian journalists produced their own share of "drug scare" stories, but also offered more balanced accounts such as that provided by David Suzuki's *Nature of Things* special on CBC, "Dealing with Drugs." This program contrasted harm reduction approaches in Liverpool and Amsterdam with the drug war in New York, and examined Canadian efforts at grappling with drug problems.[87]

While Canada did not embrace an all-out drug war comparable to the American effort, its policy seemed beset by ambivalence regarding both priorities and objectives. This contradiction was suggested by the terminology used by federal officials in describing Canada's Drug Strategy. The focus on demand reduction over supply measures began to erode. Perrin Beatty, the Minister of Health and Welfare, struggling in 1990 to describe the Canadian policy, said: "We believe that the first course of action in *combatting* drug abuse is to *help* the drug user or *potential* drug user. While the *major priority* is demand reduction, curbing supply is *equally important*, especially as a *complement* to demand reduction efforts."[88] The 1990 RCMP drug report not only documented falling prices and greater purity of cocaine, but also projected easier availability of almost all illegal drugs in Canada in the next two years.[89] In this context, the Solicitor General, Pierre Cadieux, who was less restrained in the use of war-like imagery, remarked: "What we're saying is that the *war* has not been *won* yet but that we are making steady progress." One can only wonder what a "setback" would be.

It has been difficult to know who spoke for, or indeed who defined Canada's Drug Strategy. There are many players, including ministers sharing cabinet responsibility, police officials, federal and provincial

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civil servants, and all those from addiction agencies who participated in community consultations across the country. The leadership of the Canadian Centre on Substance Abuse (CCSA), created by the 1987 initiative, saw the Strategy as a tentative step in the direction of harm minimization.[90] As an example of this new direction for the future of Canadian drug policy, the Chief Executive Officer, Jan Skirrow, said:

> A successful attack on the harm associated with drug use will require comprehensive social policy... every aspect of how human beings organize and govern themselves becomes an issue, because drug use is associated with nothing less than who we are as individuals, how we see our world and our place in it, and how we exercise our individual skills and abilities to live life as we wish.[91]

The annual report for 1990–1991 of the CCSA specifically speaks out against an American-style supply reduction focus; it emphasizes the need for "a humane and uniquely Canadian alternative to the punitive War on Drugs."

While it is premature to determine the shape drug policy will take for the rest of the 1990s, recent statements provide certain indications. Federal ministers announced the renewal of Canada's Drug Strategy in March 1992 for a further five-year period, with a budget of $270 million.[92] The Minister of National Health and Welfare remarked that while the "remarkable success" of the Strategy was illustrated by declines in illicit drug use, especially among young people, the problem of substance abuse still existed.[93] The aim was said to be harm reduction, and the key elements were prevention and health promotion; a number of high risk groups were targeted for future attention.

The Solicitor General highlighted specific funding of $33 million for three new units to specialize in the enforcement of the Proceeds of Crime laws. He confirmed plans for the RCMP and the Department of National Defense to extend their cooperative arrangement to include both coastal surveillance and assistance on land. Also included was a plan to share forfeited crime profits with the provinces, an apparent victory for those who have argued that these funds should return to local coffers rather than go into general federal revenues. The involvement of the military and the return of seized drug assets to the police characterize current American practices. The Strategy's emphasis on demand-side measures focused on continuing

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and strengthening the police role in drug education: "It's no exaggeration to say that now, Canadian police forces lead the western world in the police-delivery of the drug abuse awareness, the drug prevention message to youth."[94]

The pronouncements surrounding the renewal of Canada's Drug Strategy appear to represent a subtle shift of emphasis. While previous statements favored a "balanced" approach, the scales of influence have tipped disproportionately to the enforcement sector, focusing both demand and supply efforts in the police. What is not explicit in this, or in the first version adopted in 1987, is recognition that the dominant policy remains one of criminalization. Nor are the various costs and limitations of the effectiveness of this approach addressed.[95] Despite the care and concern expressed for young people, the fact is that adolescents and young adults are still arrested in large numbers (mainly for cannabis), go to court, get criminal records, and are often imprisoned. Indeed, the evidence demonstrates increased criminalization. With respect to drug policy, a recent all-too apt comment was: "Canada's bite is worse than its bark."[96]

A cynical view of the renewal of Canada's Drug Strategy might be that the catch phrase "harm reduction" is putting a new face on the established policies of prohibitionism. The downward trend in illicit drug use, already well established before the advent of the Drug Strategy, is heralded as its achievement. Personal testimony and "informed opinion" appear to be sufficient to declare the Strategy a success. If "policies are judged by their consequences but crusades by how good they make the crusaders feel," then Canada is still in search of a coherent and effective drug *policy*.[97]

An alternative, more charitable, view of recent developments in Canadian drug policy is that political leaders and other federal and provincial officials deserve credit for resisting an all-out drug war. Demand reduction was made a funding priority. Tangible benefits of the Drug Strategy include the direction of resources to treatment programs and other community projects, the training of addiction professionals, the greater involvement of Native communities in various programs, and the improved communication and coordination of addiction groups across the country.[98] The continuation of the Drug Strategy for another five years provides time to reshape the approach, perhaps redirecting enforcement efforts to more community-based ways of maintaining public order and supporting treat-

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ment efforts. The many voices involved in drug policy decisions would seem to ensure a more even-handed approach.

## CONCLUSION

A Canadian, attending an international conference, recently asked an Australian what accounted for that country's greater success in taking innovative approaches to illicit drug problems. The Australian approaches, for example, have included early needle exchange programs, plans for a pilot heroin maintenance program, and a ticketing system for marijuana possession. The Australian reply was, "we're just lucky to be so far away from the United States."[99] Proximity may be one factor. The influence of the American media, and political and economic pressures, is felt more directly in Canada and perhaps in Mexico, than in many other countries. But other factors beyond the dominance of a smaller country by its larger neighbor also contribute. The inertia of Canada's own history, its tradition of repressive laws and criminal justice institutions and procedures, impede fundamental change in drug policy.

Canada's drug problems are considerably less serious than those in the United States, but the policies pursued in recent years reveal parallel trends. For a brief period, it appeared that a continued heavy reliance on criminalization as the dominant policy was waning, that Canada had learned from its own experiences with prohibitions, as well as those of its neighbor. For the past two decades, conflicts over the appropriate societal response to drugs in Canada have produced fluctuations ranging from great public interest, to increased tolerance during the newer wave of marijuana use, to less severity of penalties, followed by relative indifference, and then a return to increased public concern and heightened punitive responses. More recent antidrug sentiment and adverse social evaluations of drug takers may have been fostered by the drug scare over cocaine and crack use.

Twenty years ago, the Le Dain Commission (1972) set an overall goal of Canadian drug policy to achieve gradual withdrawal from criminal sanctions against the user, with the development of alternative means to discourage use and reduce harm. To continue to rely on criminalization of users and expanded enforcement activity impedes the development of less punitive interventions. The attempt to shape Canada's Drug Strategy in a new direction appears to have been

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compromised by a basic allegiance to prohibitionism, the perpetuation of established traditional approaches, and the further funding support for enforcement.

What elements could contribute to a more constructive drug policy, and what features could likely reduce the harmful consequences of drug use? A useful potential alternative could be rooted in a public health perspective and its harm reduction paradigm.[100] As a point of departure, public health-oriented thinking questions the supply-demand dichotomy as the only dynamic for the control of substance use. A principal societal goal in health care is to maximize the health and well-being of the populace through the treatment and prevention of illness and the minimization or elimination of exposure to factors that adversely affect health, especially of the young.[101] Elimination may be desirable, but if not completely attainable, effort can be focused on using regulatory controls to set standards of public safety and the minimization of risk.

For example, if one considers potentially dangerous activities voluntarily engaged in, a comparison of cocaine use and snowmobile use provides an interesting contrast in policy approaches. Deaths related to each of these activities are of similar magnitude in the province of Ontario;[102] both have been a matter of public concern, but the means sought to reduce the harm of snowmobiles include licensing, age restrictions, instruction on safe use, specific areas for use, and warnings about combining alcohol and snowmobile driving. There have been no efforts to ban snowmobiles or imprison their users or sellers. Essentially, in the public health model, society seeks to learn the least destructive ways to live with a certain level of activities—for example, alcohol and tobacco use, the driving of motor vehicles—and endeavors to minimize harm through a variety of less coercive means than criminal punishment. Criminal penalties, with respect to drug issues, are reserved for combining use with activities such as drinking and driving, that pose special risks to the safety and well-being of others. Restriction of availability is necessary for risk minimization and may involve a variety of strategies.

Harm reduction paradigms are a more recent elaboration of general public health principles that have been prompted, in part, by the AIDS epidemic among injection drug users in several countries. Several key *concepts* relevant to policy development have emerged as these approaches have been extended to other forms of individual

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and social harm related to drug use. One feature is that abstinence is not always the only appropriate objective of policy. Second, harm reduction strategies recognize that prohibition in and of itself can generate certain types of harms, at both the individual and societal levels, in direct proportion to the vigor of implementation. Third, the drug user is viewed as a member of society, and may need treatment and assistance to reintegrate into the community. Fourth, harm reduction is most often a community-based strategy and places as much or more responsibility for effectiveness on strategic partnerships than in formal institutional interventions. Fifth, some forms of legal controls and their enforcement may be essential for harm reduction but need to be integrated into an overall strategy.

A practical example of how this might apply in Canada concerns cannabis offenses. The addition of cannabis to the *Narcotic Control Act* in 1923, which has been described as a "law without a problem,"[103] may now create more problems than it solves. A new objective for the renewal of Canada's Drug Strategy might be for this country to *lose* its standing as one of the world's leaders in per capita drug arrests. This might be accomplished by stopping much of the cannabis possession enforcement activity and reducing the emphasis on small-scale traffickers. If enforcement against such offenders were curtailed, the results would likely be a net reduction in individual, social, and economic costs. Such measures could lead to significant savings of public resources, which could then be used to fund harm reduction strategies in the community, or directed to other pressing social problems. Similar arguments could be considered with respect to users of other illicit drugs, who may be in even greater need of treatment or support than cannabis users.

Observers of drug policy trends in Canada, looking towards the year 2000, consider several questions: Was the recent modest relaxation of prohibitionism merely a transient anomaly? Is the drug scare destined to be a permanent public feature that will support continuation of repressive policies? Will Canada chart a new course within the evolving model of harm reduction? Canada's prohibition policy was forged in a different era, in a very different Canada, and has dominated official response to drug use for about a century. Serious alternatives were first articulated by the Le Dain Commission. It is time to explore what a health-directed public policy for drugs could mean for Canada.

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[99]The exchange occurred in a plenary session of the Third International Conference on the Reduction of Drug-Related Harm, Melbourne, Australia, 23–27 March 1992. Various sessions at the meeting also highlighted these Australian examples.

[100]John Ashton and Howard Seymour, *The New Public Health* (Milton Keynes: Open University Press, 1988); and P. O'Hare et al., eds., *The Reduction of Drug Related Harm*.

[101]P.H.M. Lohman, K. Sankaranarayanan, and J. Ashby, "Choosing the Limits of Life," *Nature* 357 (21 May 1992): 185–86; and Patricia G. Erickson, "A Public Health Approach to Demand Reduction," *Journal of Drug Issues* 20 (4) (1990): 563–75.

[102]B. Rowe, R. Milner, C. Johnson, and G. Bota, "Snowmobile-related deaths in Ontario: A 5-year Review," *Canadian Medical Association Journal* 146 (1992): 147–52; and Chief Coroner's Office of Ontario, 1991.

[103]Giffen et al., *Panic and Indifference*.

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DRUG ARRESTS BY STATE AND LOCAL AUTHORITIES

| | 1979 | 1988 |
|---|---|---|
| Total state/local arrests | 558,601 | 1,154,046 |
| Sale/Manufacture | 101,107 | 316,525 |
| Heroin/cocaine | 20,688 | 196,384 |
| Marijuana | 49,715 | 64,691 |
| Other | 30,164 | 55,450 |
| Possession | 457,494 | 837,521 |
| Heroin/cocaine | 47,481 | 403,165 |
| Marijuana | 341,305 | 326,922 |
| Other | 68,708 | 107,434 |
| Federal arrests[a] | 6,343 | 15,750 |
| Marijuana | 1,690 | 4,890 |
| Heroin/cocaine and other | 5,653 | 10,850 |

[a]Defendants charged with violations of Drug Abuse Prevention and Control Act in U.S. District Court; not necessarily arrested in that year.

SOURCE: FBI, Uniform Crime Reports, and Administrative Office of the U.S. Court.

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*Dwight B. Heath*

# US Drug Control Policy: A Cultural Perspective

IN AUGUST 1989, THE NEW PRESIDENT GEORGE BUSH gave his first televised address to his constituency. In an unusual move, he devoted his entire speech to a single subject, a call to arms in a "war on drugs." This topic struck a responsive chord, and during the next several months the media were full of feature stories, editorials, news reports, and background accounts about "the drug menace," "drug lords and cartels," the "war on drugs," and many other variants on the theme of drugs as the enemy of the collective American people. The imagery of war was a rhetorical device designed to galvanize public opinion, to rally support, and to draw a sharp line between "us" and "them." The rhetoric of other recent presidents on "the war on poverty," the "war on illiteracy," and, much earlier, the "war against drink" had been applauded, and this topic served to demonstrate the speaker's decisiveness. Presidential popularity as measured in public opinion polls typically zooms in times of confrontation. By declaring a war on drugs, Bush, characterized as a wimp during his eight years as Vice President, recast himself as a "tough guy" who identified a major threat, announced a firm stand, and promised to take forceful action.

It is unfortunate that this country seems to need to target an enemy. An old pattern, this is evident today in the public opposition to Japan that emerged just as tensions with the former Soviet Union were ending. Looking at the past forty years, the Cold War itself immediately followed World War II. Iran was considered a valued ally under the Shah, but became an archenemy after the revolution;

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similar reversals took place with respect to Cuba and Nicaragua. Even nonthreatening Granada and Panama held center stage briefly in recent confrontations, and Iraq's Saddam Hussein has eclipsed even Libya's Muammar el-Qaddafi as a personalized villain.

Within a month of President Bush's speech on drugs, public opinion polls reported that nearly 65 percent of the people identified drugs as "the major issue facing this country," and there appeared to be a consensus supporting a militant agenda against drugs. The imagery of war not only caught people's attention and won strong support from the media; it also spoke to attitudes and values that have deep roots in the US national character.

Ostensibly to facilitate coordination and strategy of this major campaign, a new Office of National Drug Control Policy was established. Placed within the White House, it was effectively insulated from influence by the Department of Health and Human Services, the Department of Justice, and other agencies already involved in drug use and its effects. William Bennett directed the newly created post, popularly dubbed "Drug Czar." His thinking about drugs was not prejudiced by any previous knowledge on the subject. In keeping with the "tough guy" approach, he promptly declared a policy directed almost exclusively to the supply side, aimed at keeping drugs from coming into the country, and failing that, keeping them from the public.

Researchers and clinicians long involved with drug users tend to favor instead a demand-side approach, such as decreasing interest in using drugs through education programs, and, failing that, providing facilities and services for treatment and rehabilitation. As is often the case in time of war, the continuing needs of public health and social welfare were preempted by militant gestures and hardware. Fully 70 percent of the generous budget of the new drug policy was assigned to military or paramilitary police approaches aimed at interdiction, eradication, and disruption of sales. This inversion of what most people in social services view as appropriate priorities did not succeed in creating a "drug-free America," but it did succeed in making the war on drugs a reality.

## THE SUPPLY-SIDE APPROACH TO DRUG CONTROL

Following the tone set by President Bush and Director Bennett, national drug control policy quickly took on an aggressive mien.

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Much of the war on drugs, since the early stages, has taken place out of sight of the populace and media of this country. Large grants were supplemented by training and equipping the armed forces and the national police of those countries where the offending "hard drugs" are produced. Such aid—which included the cold, hard panoply of military hardware, linked with assault tactics, armed containment, and related actions—was intended to support local efforts at eradicating coca, cannabis, and opium poppy, which have long been important cash crops to those countries. In some instances, crops were raided, and plants were uprooted and burned. Elsewhere, chemical defoliants and herbicides have been sprayed from the air, creating devastated areas such as in conventional war zones. In parts of the Andes, peasant farmers are being paid not to plant coca on the terraces near towns where it has been grown for centuries, to allow for crop substitution or "alternative development." In reality, none of the new crops offered has anywhere near the profit incentive of the internationally trafficked illicit drugs. Thus farmers soon return to cultivating the old crops in different areas.

In Latin America, the local people complain about the United States' military presence. Even if US troops are not directly engaged, they appear to have invaded. They are highly visible in support of local armed forces who often pillage and harm civilians as they search for drug sources.[1] Even observers who oppose drug trade comment that the military or police forces do more harm than good, whether by harassing small-scale farmers, defending against local insurgency, or taking bribes in exchange for helping the drug dealers.

Earlier in the war on drugs, the Pentagon was reluctant to get involved in what appeared to be another futile operation. However, with the collapse of the Soviet Union, when people began to talk about a "peace dividend," the funds anticipated from progressive disarmament, the Department of Defense quite abruptly joined the war on drugs. Pentagon involvement has resulted in escalating US military investment in drug-producing countries, with more personnel following more money and equipment. Although media coverage is sporadic, there are now large contingents of the US military in place to complement Drug Enforcement Agency operatives as "trainers" and "observers," for example, in Peru.

Jeeps, guns, radios, ammunition, helicopters, and other kinds of military supplies and equipment have been provided so lavishly that,

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by the time of the second inter-American drug summit in late February 1992, the presidents of both Bolivia and Colombia declined further assistance. Although not stated publicly at San Antonio, at home they expressed their concern for the security of their governments in the face of increasingly powerful and corrupt military presence.

Numerous reports from the Drug Enforcement Agency, General Accounting Office, Department of State, and other governmental agencies have repeatedly deplored the large cost and small return from the current administration's supply-side drug control operations.[2] Efforts at eradication are doomed to failure, given the ubiquity of ecological niches in which drug crops can be grown. In fact, one striking result of the recent effort has been the expansion, rather than contraction, of areas devoted to drug cultivation.

Another example of the US military commitment is the large numbers of planes and ships deployed in monitoring air and sea traffic bringing drugs into this country. Such an attempt at interdiction is quite futile, especially given that profit margins are so great that 1) smugglers readily abandon planes or boats likely to be intercepted, and 2) there is no shortage of willing personnel at any of the many stages of production and distribution of the contraband. To date, insignificant amounts of drugs have been intercepted; few factories have been destroyed; and virtually no traffickers have been caught beyond US boundaries. The most vivid proof of the futility of the military's role and a supply-side approach is the well documented fact that the targeted drugs have probably never been more abundant, less expensive, or of better quality than now, years after President Bush's declared goal.[3]

The futility of supply-side approach is evident in this country as well as abroad. Not only are we supporting military misadventures overseas, we are also taking and holding prisoners within our own boundaries. No nation in the world approaches the US rate of criminal confinement, and almost every jurisdiction claims that it needs more courts and more jails and prisons. Over the past decade, the crime rate (adjusted for population) remained virtually unchanged. Massive incarceration—an estimated 70 percent of it for drug related offenses—has had little effect on reducing crime.[4]

The militant approach of police and armed forces abroad is mirrored in aggressive strengthening of the domestic criminal justice

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system, which includes hardware, communications, research, etc., as well as a potentially dangerous empowerment that bends the law. William Bennett did not get full support when he recommended capital punishment for anyone who sold drugs to a minor, but there are strong calls for looser rules of evidence in drug cases, harsher and mandatory sentences, and other "get tough" policies that would differentiate drug related cases from others. There are already provisions for the forfeiture of property in that connection that are unlike anything else in our criminal justice system. Current domestic drug policy approaches martial law, with the suspension of Constitutional guarantees. Yet, despite all the military context, trade flourishes, and quality drugs are easily available and inexpensive, as paradoxical as that may seem. A brief overview of the ambivalent relationship between humankind and drugs over the years may illuminate some of the factors involved.

## A CULTURAL PERSPECTIVE

In one sense, the view of drugs as "the enemy" has been widespread and persistent. However, it is important to recognize that this view has been applied to different drugs at different times. The warnings and restrictions associated with drugs have a familiar ring, although the substances to which they refer have changed. There is considerable confusion about what constitutes a drug, and what drugs may be more or less harmful than others. But rarely has there been such a concerted effort at achieving a "drug-free environment" as there is now.

Psychoactive drugs have been used by humankind throughout recorded history, and probably much earlier according to archaeological evidence. The tendency for creatures to alter their perceptions deliberately is so old and prevalent that some speak of intoxication as a universal human need, or even "the fourth need" for all animals.[5] Psychoactive substances alter perception, consciousness, mood, and sensation in ways that are closely linked with changes in logical thinking, often resulting in drastic changes in overt behavior. Birds, bees, and wasps cannot fly well after having drunk the juice of overripe fruits or berries, and bears stagger and fall down after eating fermented honey. Ethanol, or potable alcohol, occurs in nature as free-floating yeasts convert almost any vegetable carbohydrate to

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sugar. Hallucinogenic mushrooms and many snuffs also occur without any human intervention. In contrast, some of the psychoactive drugs that are now commercially popular are products of fairly sophisticated chemical technology.

Over time, nearly every culture has had traditional social controls over access to and use of psychoactive drugs. For example, social norms in some cultures hold that one drug be used only by males and another by females; children under a certain age are discouraged from taking drugs at all; and members of different castes, classes, occupational groups, or other categories are either expected or forbidden to indulge. At the same time, there may be other social rules defining what is appropriate and what is not, depending on time and place, other people present, or even what else one is doing at the time.

In addition to such informal controls, most literate societies have codified laws and regulations about the use of drugs. Outright prohibition of drugs is commonplace. Many in this country are calling for "zero tolerance" and a drug-free society, as in the "Just Say No" campaign. At the same time, there is a strong current of opinion favoring a more liberal approach to drug use, variously referred to as "legalization," "relegalization" (following previous policies), or "decriminalization."

These countercurrents have resulted in a large and rapidly growing body of literature, often cast in terms of juxtaposed "pro" and "con" arguments. As is so often the case, realities do not lend themselves well to simplistic "either/or" arguments. No matter how accurate, well written, and thoughtful such essays may be, it is important to note that substantive data are scarce on both sides of the issue. It is difficult to imagine what kind of methodologically and ethically sound experiments could be devised to help us weigh the alternatives in a rigorously scientific manner. What we can and should do is go beyond the almost formulaic exchanges that too often present premises as if they were conclusions, and that represent affect as if it were data.

By adopting a cultural perspective, we can look at the United States in relation to a number of other cultures around the world, and in relation to its own historical antecedents, and thereby muster relevant evidence from a number of natural experiments. That is, while we cannot easily conduct experiments on large human populations using

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the classic scientific method of manipulating variables, what we can do is refocus our lens and pay attention to those variables as they occur in different combinations around the world.

When we take such a cross-cultural perspective, some striking facts quickly emerge. One is the great variety of psychoactive drugs that humankind has discovered and invented. Another is the great variety of uses to which they are put, not only for relaxation and recreation but more often in close and important association with religious, medical, or other practices. Similarly, there are often fads and fashions with drugs, some popular at one time, then neglected or shunned at another time. Closely related rules and norms dictate many aspects of the use of a drug, including its effects. Such rules and norms are not only prescriptive but also proscriptive, as in lists of dos and don'ts.

It may seem strange that all of the psychoactive substances that are now legal and widely enjoyed were at one time illegal and feared. For example, coffee and chocolate, which most North Americans now consider innocuous, were viewed with suspicion when they first became available in Europe and the Near East. In terms very similar to those used with respect to drugs in the 1960s, coffee and chocolate were associated with laziness, sexual license, and political intrigue. In the seventeenth century, just visiting a coffeehouse was a capital offense in what are now Egypt, Saudi Arabia, and Turkey—all places where coffeehouses are now important centers of sociability and business.[6] King James I of England wrote a diatribe against tobacco and might have banned it if his advisers had not made so much of its tax value. At various times tobacco was illegal in China, Germany, Persia, Russia, and Turkey. Its use is today rapidly being restricted in the United States, after eighty years of unprecedented popularity.

Opium was popular in India before it was introduced to China, and peyote was a religious sacrament for Mexican Indians long before it and the derivative mescaline were banned. Coca had been used for nutritive, social, and religious purposes by Andean Indians for millennia with no evidence of deleterious consequences. In the late 1800s, Freud and others viewed coca and its major alkaloid cocaine as healthful stimulants. Heroin was initially hailed as a safe alternative to morphine.[7]

The associations by which a drug falls from grace have less to do with pharmacology than with prejudice and other attitudes. The

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Opium War resulted from British violation of a long-standing ban on opium in China, yet fifty years later, the Chinese were blamed for having forced opium upon unsuspecting North Americans. The image of opium, which had been esteemed in the Western world as a stimulant to artistic creativity, became tarnished late in the nineteenth century, as the association shifted from vague exoticism to utter depravity, part of the Oriental "yellow peril" that was thought to lure away American women and erode American will and industry.

Kava was traditionally drunk in ceremonial context in much of Melanesia, but it has recently come to be viewed as dangerous when taken with alcohol. Peyote remains a sacrament among various Mexican Indian tribes and in the Native American Church, although its secular use is illegal.

Marijuana has long been used as an energizer by sugarcane harvesters in Jamaica and stevedores in Costa Rica. In the United States of the 1920s, such use was known but virtually limited to poor Blacks and jazz musicians. With the repeal of Prohibition, government agents shifted their attention from moonshine to cannabis, which they portrayed as leading to "reefer madness." Ironically, just a few decades later, the same drug was said to result in the diametrically contrasting but equally deplorable "amotivational syndrome." Widely adopted as a relaxant and euphoriant, marijuana was briefly habilitated by many in the medical community, but within less than a decade, the pendulum of opinion swung back, and both physical and mental damage are now attributed to its use. Many jurisdictions that had decriminalized its sale and use, and more its possession, have rescinded those laws, and the federal government in 1992 banned its use for medical purposes, even under prescription.[8]

During World War I, cocaine was rumored to have been a tool of German spies, and in the 1930s, the colloquial term "dope fiend" illustrated how its use supposedly resulted in a kind of amoral and antisocial madness. By the 1970s, cocaine had come to be viewed by many, including physicians and pharmacologists, as an innocuous "recreational drug," but in the 1990s it is again deplored as being addictive, a major cause of crime, and a significant threat to the next generation. The smokable derivative "crack" has an even more sinister image as it is believed to cause instant addiction.

Tranquilizers that were hailed as a boon in relieving the stresses of the 1960s have evolved, in our thinking, to play an important role

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not only in the "multiple-dependency" of those who use them but also in the "co-dependency" that is thought to debilitate many of the people who care about such users.

The recent popularity of glue sniffing as a means of altering consciousness is a case study of the user's ingeniousness, as a common industrial product has been adapted to wholly unforeseen purposes. In that instance, mass media appear to have played a role in rapidly converting a harmless tool into a dangerous drug.[9]

It is not only the lay public who are uncertain about drugs, their uses, and the meanings that should be attached to them. The common uncertainty is reflected in the confusion we see even among those who are charged with shaping and implementing drug policies. The case of alcohol is especially illuminating. Early in his service as director of the national drug control policy, William Bennett was asked about the significant number of deaths attributed to legal use of tobacco and alcohol. Bennett differentiated policy, however, on the basis of legality and exempted "soft drugs" from his program. Shortly after Bennett resigned, however, his successor made a special point of including alcohol as a dangerous substance in his first policy statement.

Beer is more important than bread as a staple food in many parts of the world and may well predate bread historically. It was an important offering to the gods in pharaonic Egypt and still is in many African and South American tribes. William Hogarth vividly depicted it in his etchings as bringing health, happiness, and prosperity to seventeenth-century London.[10]

Much earlier in history and halfway across the world, the Arab culture of Mohammed valued not only drink but drunkenness; Persian writers waxed eloquent about both in a land that is now officially dry. Similarly, poets and philosophers of ancient China sang the praises of wine and its disinhibiting effects, but prohibition was enacted throughout the empire at various times. Ambivalence about drug use is not new or peculiar to the West.

Heavy drinking was common among the colonial American public at large. Puritan ministers hailed drink as "a good Creature of God," especially where water was not safe from disease. By the 1850s, however, anti-alcohol sentiment led nearly half the states to enact Prohibition. As religious fervor rapidly waned, most such laws were repealed, but saloons soon became a new public enemy. Formerly

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considered "the working men's social club," the local barroom was denigrated as a den of iniquity, a breeding place of sedition among anarchic immigrants, or the cause of family breakup. German domination of the beer industry lent a patriotic twist to renewed calls for Prohibition, which became not only federal law but an amendment to the Constitution in 1919.[11]

National Prohibition is often derided as a failure because moonshining, speakeasies, and fashionable public drinking by women made a mockery of the law, and criminal gangs gained wealth and power in the illicit trade. Since repeal, there had been a steady rise in drinking until the 1980s, when a downward trend began which continues today. Not only are individuals drinking less, and popular beverages themselves lower in alcohol, but the whole meaning of drinking is again being refocused. A highly vocal and effective New Temperance Movement, pointing to traffic fatalities, learning disabilities, accelerating health costs, and falling productivity, and working through a number of so-called "consumer-interest groups," are attempting increasingly to limit even more the availability of alcoholic beverages by increasing taxes, reducing hours and outlets of sale, and a variety of other restrictive measures.[12]

Although they reject the label of "Neo-Prohibitionists," they were effective in imposing prohibition on anyone under 21 years of age, although the vote, the right to marry without parental permission, and other legal perquisites of majority are afforded to 18-year-olds. Although it has not yet been enacted into law, waiters in restaurants sometimes try to enforce prohibition on pregnant women, and US government publications often recommend abstention for women who might become pregnant—a sizable portion of the population—and for people who are taking any medication or planning to drive.

Social scientists often have to rely on natural experiments for evidence. From this viewpoint, the fact that official and popular attitudes toward the use of alcohol and drugs differ not only among various cultures, but that they also shift, often diametrically, within a single culture over only a few decades, strongly suggests a few points that appear simple but that may be crucial. First, we must recognize that problems are in no way inherent in an inert substance but emerge in an interaction between it, the user, and the context. As an important corollary of this, we must also recognize that the drug user is not just a biological organism being affected by a chemical. Rather,

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that individual should be viewed as a complex biopsychological system. In practical terms, this means that the user also comprises a personality (influenced by expectations, values, attitudes), a unique life history (influenced by all sorts of teachings and experiences), and a distinctive combination of statuses, many of which imply very different roles (for example, female, adult, mother, sister, aunt, godmother, professional, etc., all at the same time). Most of these and other variables that are relevant to drug use have little relationship, of a kind that might be discernible by strict scientific methods, to any psychoactive substance. Nevertheless, they interact in ways that are salient in determining use, quantity, and frequency, and even outcomes of use.

Thus many of the problems associated with drugs and alcohol, significantly, can best be viewed as social constructs. Because they have virtually no direct link to the nature of any substance, and little linkage to the way those substances interact with the human body, such problems are based instead on clusters of attitudes and associations in the minds of people. In this way, social problems can be seen to reflect opinions and prejudices of the moment, or as being highly selective among the facts that are available, rather than objectively reflecting actual events or empirical trends. This is why popular views about alcohol and drugs, and about alcohol and drug problems are so variable, and part of why "the enemy" in the war on drugs is so elusive.

Another reason why the enemy changes in the war on drugs has to do less with drugs and the problems they cause than it does with those who sell and use them. It was clear from the beginning that a war on drugs would be conducted not against neutral substances but against real human adversaries. It soon became typical that those who were "on the other side" were portrayed in terms of imagery that has deep roots in American national character. It was perhaps frightening, but in a way also reassuring, that "the bad guys" who were making huge profits outside of the law, victimizing children and other vulnerable individuals, and committing other heinous acts were mostly foreigners. We were also led to believe that they were shorter, darker people, with alien names and accents, often operating with apparent impunity in corrupt nations of the Third World.

Even within the United States, "the enemy" were predominantly represented as being ethnic minorities (especially Black or Hispanic),

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unwilling to work, probably on welfare (if not unjustly rich), far too quick to resort to violence, undisciplined and uneducated, and in many other respects deserving of collective condemnation. Contrary to the stereotypes, repeated national surveys have consistently portrayed 70 percent of drug users in this country as white, the same percent regularly employed, and nearly as many with more than a high school education and more than $25,000 annual earnings. Again in contrast to stereotypes, even those drug users who are not employed have been demonstrated to work hard and imaginatively, and to prefer a range of nonviolent "hustles" among friends to aggression or theft from a stranger.[13]

Some social scientists who bring a psychoanalytic perspective to this issue emphasize the tendency of populations to project their fears and vices onto a safely remote and outcast group, unconsciously but effectively scapegoating. The suggestion is that we "need" drug users, pushers, drug lords, and kingpins as vessels for all the negative qualities that we decline to admit within ourselves, representing them in ways that justify our "waging war" upon them, as personifications of evil.[14] All of those themes were played out, as hostile gangs (usually Latino) were said to be no longer content to fight among themselves in Los Angeles and beginning to infiltrate smaller communities, even in the previously uncorrupted Midwest. An invasion from the south was vividly portrayed, but inaccurate. Fidel Castro, who had rid Cuba of its traditional domination by drugs, was accused of wholesale drug trafficking. General Manuel Noriega—previously an esteemed ally, but in the wake of the Irangate trials, branded a "drug lord"—was brought to trial in this country even though the United States had to invade Panama to get him. Regardless of whether the war on drugs was a war, it has quickly assumed the propaganda, scapegoating, chauvinism, and other trappings of a fighting war.

In the light of the social construction of alcohol and drug problems, and the dubious portrayal of any real opponents, it is not easy to identify the enemy in the war on drugs. It is little wonder, then, that people often seek a quick fix solution via prohibition, nor is it any wonder that they almost always fail.

## PROHIBITION AS AN ANNIHILATION STRATEGY

Logic dictates that, if something is troublesome, one is better off without it. Presumably this has been at the root of the various bans

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on different drugs around the world. A striking regularity, however, is that all such prohibitions have been circumvented at the time, and almost all were rescinded by administrators who eventually judged the costs to outweigh the benefits.

This often occurs when violations of a prohibition become so commonplace that people recognize the discrepancy between law and practice, and challenge the law. If the gap yawns too large, what is challenged may be not only the specific restrictive law of prohibition, but the rule of law in general. The United States appears to have come close to this kind of anarchy in the waning days of its federal prohibition on alcohol. Canada, Finland, Iceland, India, and Czarist Russia all tried to prohibit drinking during this century, but each found that the combined ills of moonshining, bootlegging, poisoning from nonbeverage alcohol, and bribery of police and officials made for a general sense of corruption and lawlessness that outweighed whatever gains there may have been in other respects. Saudi Arabia and Iran are nation-states where prohibition appears to be relatively effective, presumably because it is so firmly embedded in religious ideology and context.[15]

If we shift our focus from the nation-state to other entities, it is noteworthy that, even after the repeal of federal prohibition, several states remained officially dry, with Mississippi the last to repeal Prohibition in 1966. There are many scattered counties and communities that still forbid sale under "local option" laws. Prohibition applies differentially not only to places but also to populations. Some religious groups abstain as an article of faith. The wording of the Koranic injunction about drinking and gambling is equivocal, but most Muslims interpret it as a prohibition; similarly, members of the Church of Jesus Christ of the Latter-day Saints (the Mormon church) and several other Protestant churches cite religious justification for avoiding alcohol, and some also forbid caffeine.

For that matter, prohibition is usually in effect for at least part of many societies at any given time, although we tend not to phrase it as such. One such selective prohibition is by age; a minimum age for purchase of alcohol recently was set at twenty-one throughout the United States in response to economic pressures, with the federal government withholding highway fund allocations until states complied. Other jurisdictions have set a minimum age for purchase of tobacco and even glue. In Spain, some bars are closed to those under

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eighteen—not because of the access to alcohol, but because of electronic games thought to be addictive.

For many years it was illegal to give, sell, or trade alcoholic beverages to Australian Aborigines, Swedish Saami ("Lapps"), and Native Americans ("Indians" or Alaskan "Eskimos"). Such bans were supposedly justified on the basis of a supposed "constitutional weakness" that made drinking more dangerous for those subordinated populations than for members of the politically and economically hegemonic population. It is interesting that, when offered the choice in the 1960s or later, a number of Indian reservations and Alaska Native communities in the United States remained dry; in Canada in recent years, many Indian and Inuit (Eskimo) bands and reserves have also opted for prohibition; some Australian communities are experimenting with self-imposed bans on alcohol. The outcome of such local prohibitions has been uneven, with some evidence that they exacerbate rather than relieve many problems.[16]

In other instances, selective prohibition is socially enforced with a variety of attitudes, norms, values, and sanctions, even when it does not carry the weight of law. At the height of the Inca Empire, coca chewing appears to have been the prerogative of the nobility. In Aztec society, only priests and old men were allowed to drink, except on rare religious occasions. Opium smoking was traditionally limited to the aged in many parts of southeastern Asia, as khat-chewing is still monopolized by men in the Near East. Within a single village in India, one caste drinks cannabis tea and another drinks liquor, each scorning such barbarous behavior in the other. Not only are whole polities, religious groups, and social categories characterized by differential rules about availability, but there is also selective prohibition with respect to place. Within the United States, there are increasing calls for a "drug-free workplace," "drug-free schools," and other zones of prohibition. Frequent drug testing with "zero tolerance" is being promoted for employees in the fields of atomic energy, public transportation, and public administration to protect the public interest. Rules about context for alcohol and drug use need not be limiting, however; they can also be permissive. The famous "Needle Park" in Zurich did not reflect a libertarian stance on the part of authorities toward drug use, but rather a small refuge where dealers and users might take time out from unusually restrictive laws that are strictly enforced throughout the rest of the country. Even

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Orthodox Jews, world renowned for their usual sobriety, are exhorted as part of the Purim festival to drink until they cannot distinguish the hero from the villain in a Biblical story. Likewise, drinking and the state of intoxication are integral to celebration of saints' days and other fiestas among Roman Catholics throughout Latin America.

Similar illustrations of intrasocietal as well as cross-cultural variability could be cited for most psychoactive drugs, and for many of the world's nations and their component societies. The major point is that prohibition, far from being a distinctively North American anomaly, has been an intermittent, ancient phenomenon, usually applied inconsistently on various segments of the population. This inconsistency strongly suggests that the basis for such controls is not grounded in biochemical, neurophysiological, or even psychosocial effects of use. It also hints that prohibition is unlikely to be an effective strategy for eliminating "the enemy," whether that means traffickers, users, or "problems" associated with alcohol or drugs.

## TROUBLE ON THE HOME FRONT

Just a year after President Bush won his 65 percent approval rating by declaring war on drugs, the same pollsters found only 10 percent identifying drugs as the country's major problem. Concern about illegal drugs has been diminishing since then, as has the prevalence of use. Rumblings on the home front reflect some of the complexity of what is often too glibly characterized as a homogeneous American culture.

Despite the flurry of concern that followed Bush's call to arms, media and popular concern flagged early, as economic recession worsened, and there was recognition that the highly touted policies were winning few battles and held no promise of winning the "war." The GAO and various Congressional committees issued authoritative reports that contradicted assertions of the National Office of Drug Control Policy, and revealed major flaws in both methodology and arithmetic in the Office's key publications.[17] People became aware that interdiction could not be effective, and that there was not even support for treatment of those addicts who requested it. Although few US citizens were aware of it, growing resentment of US drug

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related intervention abroad was eroding the support of some of our allies.

Another aspect of the war on drugs that some prefer to ignore, and others would eagerly change, is the mushrooming rate of prison construction and incarceration. While the Attorney General rates this as a sign of success and calls for more prison space as the only alternative to more crime, a growing number of critics view with dismay the expansion that has already occurred, and consider it a monument to society's failure in terms of economic opportunities, racial discrimination, and education.[18]

Poverty, broken families, and unacculturated immigrants are often cited as important causal factors, but the experience of other countries and historical precedent in the United States both suggest that more fundamental factors must be involved. Selective detention may be part of the problem, with a persistent pattern of racial and ethnic prejudice acted out daily when police harass innocent members of one group and are overly tolerant of another. This is not a universal pattern, but it occurs far too often. Similarly, repeated studies have shown that, although justice cannot be bought in a simple straightforward transaction, minority suspects with lower income and education are disproportionately booked by police. In 1989, with Blacks comprising 12 percent of the population, and a similar percentage of drug users, 42 percent of drug arrests involved Blacks. In the same way, among defendants who are tried, those of minority status, with lower income and education, are disproportionately sentenced, and their sentences are consistently and significantly more severe, even for similar offenses.[19] To call such discrimination genocidal is a polemical overstatement, but to call it normal would be a terrible indictment of our legal system.

In a sense, even those who are not members of the discriminated minorities are being hurt by the heavy involvement that the criminal justice system has in prosecuting the war on drugs. In many jurisdictions the police are so burdened with drug issues that other aspects of their work are often neglected. Courts are incredibly overcrowded, as are jails and prisons. Associated costs add a significant burden to already strained budgets, resulting in escalating taxes that weigh heavily on already overtaxed constituents. An inner-city individual's occasional success (in wealth, prestige, and so forth) associated with drugs is taken by many as evidence that the system is failing and

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amoral behavior is rewarded. However rare they may be, each instance of corruption among police, judges, and other governmental agents carries the same message. Most police authorities agree that drug users are more often victimized than aggressive, and that the vast majority of violence done by dealers is directed at competitors rather than innocent bystanders. Rightly or wrongly, drugs are associated with the high dropout rate in schools, slow learning, teenage pregnancy, accelerating unemployment, falling productivity, the cost of social welfare, and a host of other aspects of contemporary life that people find annoying and discouraging.

Ironically, some of the problems that can be directly and unequivocally linked with excessive use of drugs—such as the costs of rehabilitation and treatment, or maintenance of impaired infants—are even more significant than those recognized by many who complain most loudly about drugs and their negative impact on society. This can be taken as another very different kind of evidence to support the view that public problems are socially constructed. In a social construction, what is left out may be no less important than what is included.

What is being ignored in the dominant image of the drug problem in the United States today is the fact that so many of the ills that are cited derive more from the prohibition policies that are in effect than from the use of drugs as such. Ethan Nadelmann phrased it succinctly: "The greatest beneficiaries of the drug laws are organized drug traffickers. The criminalization of the drug market effectively imposes a de facto, value-added tax that is enforced and occasionally augmented by the law enforcement establishment and collected by the drug traffickers."[20] The same occurred earlier with the prohibition of alcohol in the United States, and more recently with strict controls on the availability of alcohol in the former Soviet Union.

## HOPE FOR AN ARMISTICE

The connections between drugs, crime, violence, and disturbed youth are complex, but the experience that other countries have had with public maintenance of drug-dependent persons, together with the artificially inflated prices that illegality imposes, and the politically corrupting influence of the huge sums involved, all suggest that it is counterproductive to leave monopolistic control of production and

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distribution of now illicit drugs in the hands of criminal entrepreneurs.

The fallacy of such action, or inaction, has driven many to contemplate appropriate terms for an armistice in the war on drugs. Specific details can be worked out later, but if we again turn our attention to natural experiments as they occur in cross-cultural experience, the broad outlines of crucial first steps appear clear.

One of the leading nations in the liberalization of drug laws is the Netherlands, following the governing principle of its public health system—to minimize harm. The Dutch policy distinguishes between "hard" and "soft" drugs but avoids driving those who need hard drugs into the underworld to survive. Heroin and cocaine are available, at reasonable prices and with hygienic apparatus, in government clinics. Although the sale of marijuana by unlicensed individuals is still illegal —to curb pushers who profit from engaging new users—anyone may buy it in the many coffeeshops that are designated outlets, marked by a discreet silhouette of a leaf displayed in a window. The Dutch system is not libertarian, as it is often mislabeled; half of those in prison are there on drug charges. Neither is the country encouraging a generation of dropouts. It has become a favorite hangout for expatriates from around the world, but, contrary to dire predictions, this policy, in combination with easy availability of treatment, has resulted in a reduction rather than an increase in the number of addicts. The Dutch also have a much lower rate of incidence of overdose, and of HIV seropositivity, in comparison with the United States.[21]

An early experiment with governmental monopoly of "hard drugs" took place in England but was cut short by the Conservative government. On a smaller scale, a program in Liverpool continues to do much to normalize the lives of addicts by making drugs available at clinics under safe conditions and with encouragement of self-help group therapy and other treatments, which appear to be enjoying at least as much success as freestanding programs.[22] In such a situation, addicts can hold regular jobs and take part in a wide range of community activities that would be closed to them in a context of prohibition. In a way, the Liverpool alternative is not markedly different from methadone maintenance offered at many places in the United States. No one doubts that methadone is addictive in the sense of creating a regular craving and physiological dependency; users

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suffer classic withdrawal syndrome if they are deprived of it too long. But it is a legally controlled drug, doled out regularly at clinics around the country, and widely accepted as preferable to heroin, which remains prohibited. The dubious logic of this licit/illicit (or soft/hard) drug distinction has been challenged by minority group spokespersons who resent state-supported alternative addiction at a time when they are told that funds for treatment are not available, even while facilities have long waiting lists of those who want to rehabilitate themselves.

Legalization of drugs need not be viewed as a single giant step in which all restrictions are abruptly removed, resulting in a chaotic free market. Again, the parallel with the repeal of national prohibition on alcohol is relevant. The federal government retained some oversight over production, quality control, and so forth, as well as taxing both fermented beverages (wines, beers, ales, and related drinks) and distilled beverages (hard liquor). A remarkable degree of discretion was given to the individual states, some of which allowed for "local option" at a lower level. Even so, alcohol remains one of the most regulated products available, in terms of licensing, location, time, pricing, and advertising.

In any such program, realistic education about alcohol and drugs and the outcomes of their use should be a cornerstone. The salutary experience of the Framingham (Massachusetts) heart-health study and that in Pawtucket (Rhode Island) demonstrate that public education can be immensely effective in promoting salubrious changes in behavior, despite the skepticism voiced by many in the drug field. The discrepancy probably results from a narrow interpretation of education, as if it were restricted to material taught in the classroom, often by individuals who are neither knowledgeable nor particularly interested in the subject. When serious efforts are made to educate an entire community, however, engaging grocery stores, scout groups, civic action organizations, churches, and other institutions as well as schools and the media, abundant knowledge can be effectively communicated in ways that affect attitudes and behavior, reflected in significant changes in the incidence and prevalence of various illnesses and other health problems.[23]

The futility of the drug war in its present mode—both abroad and on the home front—suggests that it is time to call an armistice. Continuing legal prohibition as the major strategy for combating

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drugs is to attempt the impossible, by means that have already been discredited. Historical and cross-cultural evidence suggests that a wiser course would be to aim for a realistic accommodation. This would not mean "surrender" to the drug lords nor would it usher in a period of reckless anarchy. Perhaps it would be less threatening to the narco-military complex if we used terms like "liberalization," rather than legalization, relegalization, or decriminalization. To allow people legal access to a substance does not mean that they need have unrestricted access to unlimited quantities. It might even be feasible for different jurisdictions to set up some natural experiments by adopting different specific regulations within a broad pattern of liberalization. In that way, we could soon anticipate quasi-scientific evaluation of the outcomes, valuable information that could eventually serve as substantive data for making more confident choices among alternatives in terms of public health and social welfare, as well as efficiency and efficacy. Instead of suffering a defeat, such actions would, in the long run, signal a major victory for the people who are always the ones to suffer most in any kind of war.

ENDNOTES

[1]Some vivid and accurate depictions of abuses carried out in Latin America on behalf of the war on drugs are in Scott B. MacDonald, *Mountain High, White Avalanche: Cocaine and Power in the Andean States and Panama* (Westport, Conn.: Praeger, 1989); William O. Walker III, *Drug Control in the Americas* (Albuquerque: University of New Mexico Press, 1985); and Edmundo Morales, *Cocaine: White Gold Rush in Peru* (Tucson: Univeristy of Arizona Press, 1990).

[2]Among US Government publications, probably those that are most highly critical of the militant war on drugs are a number of General Accounting Office reports on individual countries in Latin America.

[3]It seems inappropriate here to reiterate specific numbers of costs, interceptions, etc., that have so often been cited in a way that discredits the efficacy of a supply-side approach to drug control. Many are given in clear and forceful context in Ethan Nadelmann, "Drug Prohibition in the United States: Costs, Consequences, and Alternatives," *Science* 245 (1989): 939–47.

[4]Data on prison populations and crime rates are from Federal Bureau of Investigation, *Uniform Crime Reports* (Rockville, Md.: Justice Statistics Clearinghouse); US Department of Justice, [annual]; and Department of Justice, *National Crime Survey* (Rockville, Md.: US Department of Justice, [annual]). See also note 18.

[5]It was a psychiatrist who postulated altered perception as a universal human need— Andrew Weil, *The Natural Mind: A New Way of Looking at Drugs and*

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*the Higher Consciousness* (Boston: Houghton Mifflin, 1972), and a pharmacologist who called intoxication "the fourth need" for all animals—Ronald Siegel, *Intoxication: Life in Pursuit of Artificial Paradise* (New York: E.P. Dutton, 1989).

[6]The early prejudice against coffee in the Near East is vividly described by R.S. Hattox, *Coffee and Coffeehouses: The Origins of a Social Beverage in the Medieval Near East* (Seattle: University of Washington Near Eastern Studies 3, 1985).

[7]Opium, peyote, cocaine, and heroin are all discussed in historical context by David Musto in *The American Disease: Origins of Narcotic Control*, rev. ed. (New York: Oxford University Press, 1989). Coca and cocaine are given special attention in Lester Grinspoon and James Bakalar, *Cocaine: A Drug and Its Evolution*, rev. ed. (New York: Basic Books, 1985).

[8]Marijuana is also treated by Musto; it is focal in Lester Grinspoon, *Marijuana Reconsidered*, rev. ed. (Cambridge: Harvard University Press, 1977).

[9]The diffusion of glue-sniffing practices in the United States appears to have followed media accounts closely, as described in Edward Brecher, *Licit and Illicit Drugs: The Consumers Union Report on Narcotics, Stimulants, Depressants, Inhalants, Hallucinogens, and Marihuana* (Boston: Little, Brown, 1972); a strikingly similar process occurred in Canada according to Bruce Alexander, *Peaceful Measures: Canada's Way Out of the War on Drugs* (Toronto: University of Toronto Press, 1990).

[10]The history of beer is vividly recounted by Alan Eames, *Blood, Sweat, and Beer* (San Francisco: Milk and Honey Press, 1992).

[11]Drinking as an integral part of American culture is portrayed in Mark Lender and James Martin, *Drinking in America: A Social-Historical Explanation*, rev. ed. (New York: Free Press, 1987), and William Rorabaugh, *The Alcoholic Republic: An American Tradition* (New York: Oxford University Press, 1979). An unusually perceptive interpretation of social factors that led to US prohibition is Joseph Gusfield, *Symbolic Crusade: Status Politics and the American Temperance Movement*, 2nd ed. (Urbana, Ill.: University of Illinois Press, 1986).

[12]Rapid and dramatic changes in attitudes toward alcohol use and its outcomes in the United States have been chronicled by Carolyn Wiener, *The Politics of Alcoholism: Building an Arena around a Social Problem* (New Brunswick, N.J.: Transaction Books, 1981). How drinking and driving became socially constructed as a major problem is the subject of Joseph Gusfield's book, *The Culture of Public Problems: Drinking-Driving and the Symbolic Order* (Chicago: University of Chicago Press, 1984). See also Dwight Heath, "The New Temperance Movement: Through the Looking Glass," *Drugs and Society* 3 (1989): 143–68.

[13]Data that shatter popular stereotypes about drug users in this country figure prominently in a variety of pamphlets issued periodically by the National Clearinghouse on Drug and Alcohol Information, of the Department of Health and Human Services. A classic account of how energetically and imaginatively drug addicts work to support their habit is Edwin Preble and James Casey, "Taking Care of Business: The Heroin User's Life on the Streets," *International Journal of the Addictions* 4 (1969): 1–24. Detailed analysis of several imaginative

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"hustles" and the insightful ways in which they are used is provided by Barbara Lex, "Narcotics Addicts' Hustling Strategies: Creation and Manipulation of Ambiguity," *Journal of Contemporary Ethnography* 18 (1990): 388–415.

[14]The apparent need for a scapegoat group upon whom a society's vices can be projected is effectively synthesized in Howard Stein, "Alcoholism as Metaphor in American Culture: Ritual Desecration as Social Integration," *Ethos* 13 (1985): 195–235.

[15]Widespread fear of lawlessness during US Prohibition is described in Harry Levine, "The Birth of American Alcohol Control: Prohibition, the Power Elite, and the Problem of Lawlessness," in Susanna Barrows, Robin Room, and Jeffrey Verhey, eds., *The Social History of Alcohol: Drinking and Culture in Modern Society* (Berkeley, Calif.: Alcohol Research Group, 1987). For a cross-cultural critique of prohibitions, see Dwight Heath, "Prohibition or Liberalization of Alcohol and Drugs: A Sociocultural Perspective," in Marc Galanter, ed., *Recent Developments in Alcoholism*, vol. 10 (New York: Plenum Press, 1992).

[16]The pros and cons of prohibition on Indian reservations continue to be hotly debated, both within the Native American communities and among scholars. Major portions of some key journals have been devoted to the question, including *Contemporary Drug Problems* 17 (1990), and *American Indian and Alaska Native Mental Health Research* 5 (1992).

[17]Simple but fundamental errors in the NODCP's reports were highlighted, for example, in the US Senate Committee on the Judiciary, *Report on National Drug Control Policy* (Washington, D.C.: United States Government Printing Office, 1991).

[18]With 455 per 100,000 of the population in jails or prisons, the United States now has the dubious distinction of leading the world in this respect. South Africa runs a distant second with 311; by way of contrast, Japan's rate is only 34. Data are from National Institute of Justice, US Department of Justice.

[19]The disproportionate number of Blacks and Hispanics arrested for drug offenses is even more striking in light of the relatively low proportion of drug users in those populations (see note 13); data on arrests are from *Uniform Crime Reports* (Rockville, Md.: Department of Justice, Justice Statistics Clearinghouse, [annual]), and those on inmates are from *Jail Inmates* (Washington, D.C.: Department of Justice, Bureau of Justice Statistics, [annual]).

[20]Nadelmann, 941. Similarly cogent critiques of the counterproductive quality of the war on drugs are two volumes by Arnold Trebach and Kevin Zeese, *Prohibition and the Conscience of Nations* (Washington, D.C.: Drug Policy Foundation, 1990) and *The Great Issues of Drug Policy* (Washington, D.C.: Drug Policy Foundation, 1990). The idea of a "narco-military complex" may first have been broached in Peter Andreas, Eva Bertram, Morris Blachman, and Kenneth Sharpe, "Dead-End Drug Wars," *Foreign Policy* 85 (1991–1992): 106–28.

[21]A sympathetic account of the Netherlands drug policy based on harm reduction is W. Buisman, *Drug Prevention in the Netherlands* (Utrecht: National Institute for Alcohol and Drugs, 1988).

[22]The advantages and disadvantages of publicly sponsored drug maintenance in Liverpool are reported in the *International Journal on Drug Policy.*

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[23]The benchmark Framingham Study has been chronicled in a series of more than thirty volumes collectively entitled *The Framingham Study: An Epidemiological Investigation of Cardiovascular Disease* (Bethesda, Md.: National Institutes of Health, 1968–present). Other community-wide health promotion programs are slowly being undertaken in many parts of the world, for example, Robert Anderson, ed., *Health Behavior Research and Health Promotion* (New York: Oxford University Press, 1988), and Robert Downie, Carol Fyfe, and Andrew Tannahil, *Health Promotion: Models and Values* (New York: Oxford University Press, 1990).

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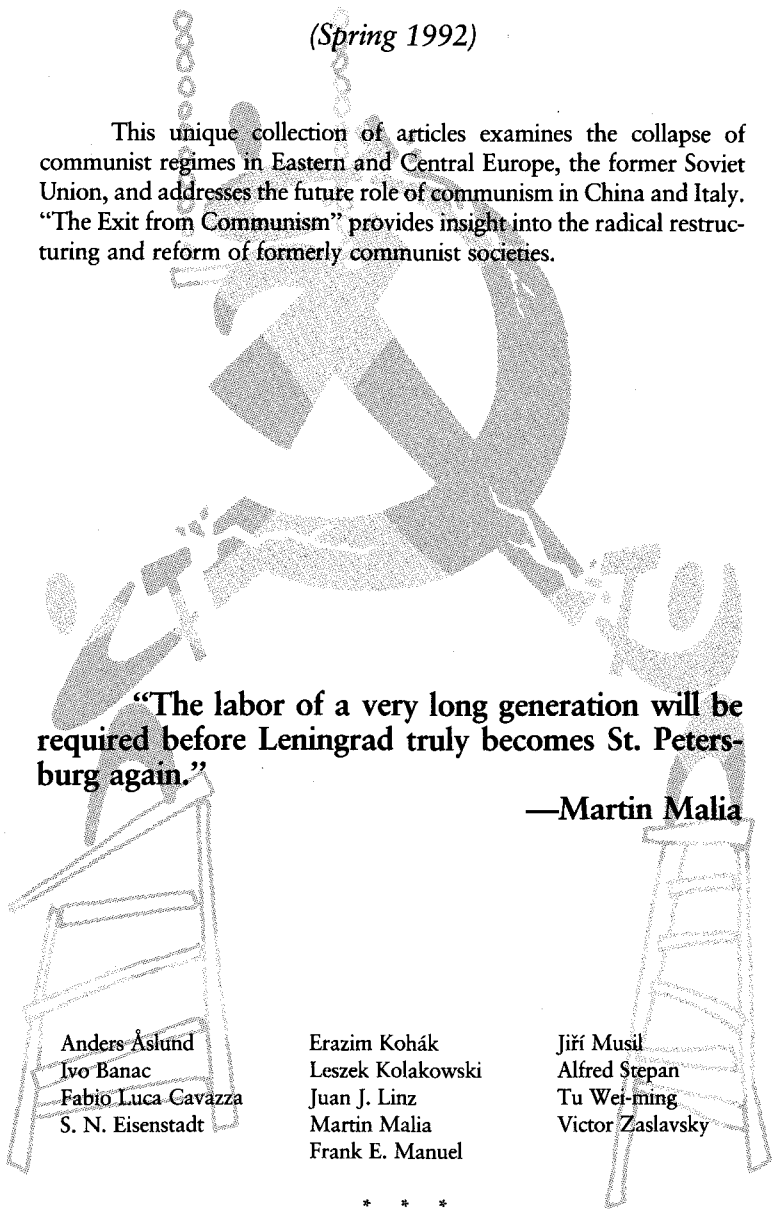

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*Jerri A. Husch*

# Culture and US Drug Policy: Toward A New Conceptual Framework

A CRITICAL ASPECT OF THE DRUG POLICY DEBATE, often overlooked or taken for granted, is the question of culture. The drug policy debate is ultimately a cultural debate. To speak of the legality, indeed the propriety of putting any number of chemicals in the human body calls into question the structure of social reality. The economic data on potential tax money lost, like the criminal justice statistics on crime rates, and the figures on lost hours of work and lower productivity—cited to support or refute current drug policies—are grounded in a particular social perspective.

For billions of human beings in a variety of geographic settings, the chewing, swallowing, inhaling, or injecting of any number of chemicals is part of an accepted repertoire of social acts. It is well known that people utilize any number of alcoholic beverages and psychotropic substances to relax, work harder, go to sleep, stay awake, hear the voices of the deity[ies], celebrate the harvest, or mourn the dead. Patterns of use vary not only across cultures but across time. Drug-taking actions and the meaning they have for people are not universal.

A particular substance's legal status is only one of many variables that reflects its meaning, providing information also on the history of its use within a society. Within a very short span of time in the United States, for example, certain patterns of alcohol and other drug use have been viewed as so problematic as to require strict laws to control, restrict, and ultimately prohibit their use, or so beneficial as to be thought a legitimate part of accepted medical practice.

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Today, despite the investment of billions of dollars, and the loss of countless lives related to the efforts in the past century of US federal drug policies, major drug and alcohol abuse problems are still targeted as critical social problems. What is it about drug and alcohol use that is so problematic? Why is the country continually plagued by a social problem that demands "war" as its solution? What, in fact, is the "problem"? What roles do drugs play within the broader social context of American culture?

It is evident that the definition of the problem differs according to social setting and context. To some observers, the problem of drugs is simply that of choice and quantity. Too much of a particular substance taken too often (or at all) is thought to be dangerous. Solving the problem means limiting the production of certain substances, regulating accessibility to others. Some are offended by the behavioral outcomes associated with the ingestion of specific substances. These outcomes are then defined as culturally unacceptable. Hallucinations, greatly increased sensory awareness, and altered perceptions of time and space are unacceptable to those people who fear these conditions.

To solve the problem, then, is to limit—through legislation and education—the number of acceptable behavioral options. Moderation and the control of personal action are deemed necessary; shouting, aggression, visions, and the loss of social constraint are all thought to be dangerous. For still others, the problem is essentially health related, and the solution is to limit the physiological damage of use to oneself or to others.

To view the problem in the ways suggested above assumes the acceptance of a culturally shared way of acting; individuals act in accordance with their common beliefs about what a particular substance will or will not do. The role that a given substance plays within a specific society will change over time. In the United States, for example, alcohol plays an important role, allowing the user "space"—to fail, or not to live up to socially defined standards of success. To be an alcoholic or to drink excessively, in a certain manner violates norms that are significant for many in the United States.[1] It is not the alcohol that is important here; it is the use of this substance in a certain way that makes it important.

The problem of drugs is not a question of chemistry but a question of culture, a menu of symbolic and concrete choices for

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action. Cultural processes give meaning to drugs. The patterns of action that surround their use are part of a larger coherent and comprehensible way of looking at the world. Drug "facts," i.e., what to use, how much to use, whom to use it with, and how to feel before, during and after use, are all cultural forms of knowledge, created, recreated and maintained through the interaction of members of a particular society.[2] To ignore the social reality of any particular form of drug taking is to invite failure when implementing policies for social change.

## WORK AND LEISURE: THE HISTORICAL CONTEXT OF DRUG USE

Humans survive by producing, in any variety of ways, the materials needed to maintain life. How those materials are produced defines in great measure the structure of the society as a whole. In contemporary America, patterns of alcohol and other drug use emerged within the framework of fundamental social and cultural changes intimately related to the structure of work. The transformation of American society from an agrarian to an industrial nation, beginning in the mid-nineteenth century, not only altered people's ways of producing goods, but also affected their drinking habits and drug use patterns.

Before the 1830s insobriety and public drunkenness, though condemned at work or elsewhere, enjoyed an accepted place in American life. Until the end of the nineteenth century, for example, alcohol in a great variety of forms—cider, rum, beer, and whiskey—served not only as food, but as medicine and tonic. Alcohol, in preparations that combined herbs and plants, such as opium, cannabis, and coca, was a part of everyday life. The ingredients, grown in gardens, or harvested in fields and woods, and fermented in backyard sheds, were converted into potions, tonics, and beverages. They were distributed to the family and the community by tavern owners, doctors, or mothers. How one responded to the substance was seen as part of a person's general character. Some "held their liquor" better than others; those who continued to be publicly inebriated were viewed as "spiritually weaker." Inappropriate use was attributed not to the substance but the person using the substance.

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The vast array of tasks necessary for survival were not separated into "work" and "play"; one ate, drank, worked, and played in an interconnected fashion. The use of any particular substance was not singled out as a primary activity. Fueled by the temperance and progressive movements, however, new standards of drinking and drug-taking behavior began to emerge in the late 1800s. One was allowed to drink, smoke, or inhale one's favored substance only at proscribed and acceptable times. These new definitions of acceptable and appropriate times were tied to the presumed requirements of industrialization. By the mid 1920s, substance use—and here again the most conspicuous example was alcohol—associated with leisure, became the preeminent form of use in the United States.[3]

The redefinition of acceptable substance use patterns was part of a larger redefinition of life patterns. "Nonwork time" or "nonproduction time" became known as leisure time, the only area of permissible insobriety.[4]

Industrialization, together with the creation of leisure time, led to the emergence of a new form of drug (and alcohol) use; it took a new name, "recreational use." Recreational patterns of use differed from "traditional" patterns; from alcohol to cannabis, the meaning of substances changed in three ways: their operational definition, their symbolic role, and their use in time and place.

First, and most importantly, psychoactive substances came to be defined only for their instrumental value. They came to be seen as objects whose meaning was derived only by their capacity to elicit mood, perceptual, and sensory change. Alcohol and other drugs are meaningful to most members of American culture today because they are a means to an end. They are a quick and easy way to alter physical sensation, a physical sensation that has been defined as positive. Many, when asked why they use alcohol and other drugs, simply answer: "to relax, get high, get drunk, or get wasted."

Alcohol and other drugs have become meaningful, however, for a second reason also; symbolically, they have a role as arbiters of personal freedom and escape. They are symbols of freedom, available to many. They are thought to provide access to feelings of freedom—a world without limits, social constraints, physical boundaries. As advertised by Anheuser-Busch, "the mountains of Busch" are clean, fresh, and empty. The blotter of LSD allows for a new "trip." Friends tell you that "chasing the dragon" will make you feel great,

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"help you forget it all." The substances symbolize a desired release. For individuals bound to the realities of daily existence, the struggle to pay the bills, keep or find a job, and fulfill all manner of social expectations, the ability to ingest a substance that promises the experience of freedom will generally not be denied. Alcohol and other drugs are an escape, a symbol of freedom that many can relate to.

Finally, the recreational use of such substances today occurs at times and in surroundings that are clearly separated from work, from daily labor. In traditional agricultural or preindustrial use patterns, coca, alcohol, tobacco, cannabis, and opium were meaningful precisely because they were embedded in a set of religious, communal, and productive activities. To drink one's cider in the field, nip at one's whiskey jug, or raise a glass of wine in a toast, was to replenish oneself, while also serving the community, with the fruits of the individual's and the community's labor. The sites for use were production sites, part of the community, a sort of extended home. Within a century all of this was completely transformed by industrialization. The modern epidemic of drug use may not be so much a matter of pharmacology as it is of how we choose to "spend" our time.

The redefinition of the workplace and of work, helped alter the patterns and meaning of alcohol and of all other drug use. The creation of the factory as the center of production radically transformed the meaning of insobriety. Drinking and drug use more generally were ultimately defined in relation to productivity and efficiency. Previously, periodic insobriety was of little consequence if it did not directly interfere with survival. One's horse, for example, could continue to plow even if the owner was inebriated; routine tasks could be completed, and perhaps even helped by sips from the cider jug. To drink alcohol and to smoke cannabis (this was especially true of ex-African-American slaves who used cannabis and cocainized tonics when alcohol was forbidden to them), or to sip on cocainized tonics like Coca-Cola was not seen as interfering with work; indeed, their use was often seen as an aid to work.[5]

The processes of industrialization redefined the structure of the workplace, the role of the laborer, the location of the means of production. Where agricultural workers' time was essentially their own, factory workers were obliged to exchange their time for wages. Industrial and mechanized forms of work, housed in centralized factories with strict rules of conduct, demanded sobriety as a

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condition of efficiency. Wealthy industrialists viewed temperance and drug reform as integral and necessary to establishing the new social order that they favored. Rational rules and requirements, formally defined business policies and worker directives replaced the more personal control strategies of another era. These scientifically "proven" and rational guidelines detailed what employees were expected to do in terms of productivity and quotas; it also detailed appropriate worker behavior in terms of attitude, punctuality, and discipline. The opium smoking of Chinese laborers working on the construction of the early railroads in the mid-1800s, like the marijuana use of Mexican migrant workers in the fields, became problematic only within the confines of urban factory production. The rules to be followed by productive employees reflected the values adhered to by "responsible" and "law-abiding" citizens. Hard work, self-discipline, strict punctuality, personal cleanliness, sobriety—these were the beliefs to be sustained. Changes in the law, from the Harrison Narcotics Act of 1914, to Prohibition in 1919, and the Marijuana Tax Act of 1937 guaranteed that the full power of the federal government would be used to sustain these moral imperatives.

> For over one hundred years employers participated in the temperance crusade because of their concern with the behavior and lifestyles of their workers. Employers believed that workers who did not drink were usually more efficient, orderly, disciplined, easier to manage and control, and less likely to make trouble on the job than workers who did drink. The "temperate" character type or life style was disciplined, orderly, hard working, frugal, responsible, morally correct, and self controlled; it thoroughly fused the Protestant ethic and the ethos of capitalism.[6]

These fundamental beliefs and attitudes with regard to work and community, God and country, were reinforced by church leaders, the family, and most notably by the structure of the schools. [7] One either followed the rules and the new moral strictures or one did not succeed, at work, in school, or in the community. New and distinct patterns of time and work were part of the emerging social order of industrial society; this new social order did not permit the retention of old, archaic, and "nonproductive" patterns of alcohol and other drug use.

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## OF TIME, WORK, AND LEISURE: THE CRISIS OF DRUGS

The tension between work time and leisure time is an important feature in understanding the current meaning of alcohol and other drug use in contemporary American society. Over the past century, work has become the preeminent activity that defines the individual's sense of self. Yet, leisure is required to utilize the objects that people spend their work time producing. It is the use of alcohol and other drugs that best symbolizes this tension between work and leisure. The tension is created by the need for a highly disciplined, rational, and efficient worker, but also by the psychological demands of a sensual, perceptive, and emotional human being with "free time" to fill.

During the first third of the twentieth century, time at work declined from approximately 60.1 hours per week to about 47 hours.[8] The change, with its attendant decrease, was primarily a result of technological advances, the activities of organized labor, and new managerial approaches to the "philosophy of production." Yet, productive output continued to increase, creating what has since become known as the "consumer society."

The emergence of captains of nonindustry, of consumption, and leisure, and a shift from singing the praises of the "heroes of production" to "heroes of consumption" in the early part of the twentieth century were encouraged by leading businessmen at the same time that they engaged in redefining the structure of the workplace.[9] The future of American productivity was seen as dependent not only on increased efficiency but on the development of new markets for the mass consumption of industrial commodities. These commodities included many newly synthesized drugs, tranquilizers among them, as well as cigarettes and alcohol. A radical transformation of peoples' attitudes towards work and play was called for; it was time not only to work hard but to "play hard."

The traditional ascetic ideology of the "Protestant Ethic," which granted preeminence to hard work and deferred gratification, was slowly eroded. In its place emerged a more hedonistic conception of leisure guided by an ideology of consumerism.[10] The modern advertising industry developed as a direct response to this continual need to create new markets and expand distribution, at the same time promoting the need to be a hard worker, to earn a decent wage. The aim of advertising became one of "creating the desire to consume,"

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and of "attempting to reshape prevailing cultural assumptions." Directed at shaping desires, wants, habits, roles, self-concepts, and identity, advertising played an enormous part in the "social production of productive consumers."[11] Advertising helped mold the prevailing cultural ideals; material goods became conspicuous as measures of success. In the need to compete continually, to increase production constantly, and to satisfy the personal desire for immediate gratification of both emotional and physical wants, a new society emerged. The ideology of consumerism that came to the fore necessitated a new vision of leisure and leisure time. Leisure came to be conceived not only as an escape from authority and the domination of work, but also as a time that allowed for "freedom of choice"—a freedom to choose and purchase "necessary" goods. Leisure came to represent the only opportunity to do what one wanted to do rather than what one had to do. Leisure, means free time—when our activities are determined not by economic compulsion, but by native impulse.[12] Recreation means free play—what we do from desire, not necessity.[13]

Increasingly, to speak of leisure was to speak of one's own time, of free time, of time defined by one's own choice. Set against work, leisure was viewed as a means of satisfying legitimate inner demands for self-expression. Leisure was seen as one of the only legitimate arenas of self-determination—the one kind of personal power available in the new industrial society.

What was denied during work time became a goal to achieve in leisure time. The ingestion of one's drug of choice—now only legitimate *outside of work*—could easily, relatively painlessly, and quite acceptably acquire new symbolic meanings; it came to be equated with self-expression, freedom, and escape.

Ultimately, leisure time was for all practical purposes equated with consumption time. Advertising for leisure activities began to focus on the principle that the personal need for self-expression could be fulfilled admirably by purchasing the appropriate goods or by the use of specific pleasure-giving substances. The creation of a consumer and leisured culture where one's emotional needs were fulfilled, paralleled the creation of a rational, controlled, efficient, and productive culture that boasted new industrial potentials.

The subsequent tension created by the conflicting demands on the individual could easily be relieved by the utilization of various

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consciousness-altering substances, all said to relieve the tensions of modern life. From aspirin to alcohol, cocainized tonics to cigarettes, since the late 1800s all such substances have been promoted as effective, rational, and practical solutions to pain and discomfort. Substances play such a pivotal role in American culture because at a symbolic and personal level they represent the citizens' inalienable right to what is conceived to be the pursuit of life, liberty, and happiness.

By the late 1930s, despite strict federal regulation, for many Americans alcohol and other drugs had become an acceptable form of recreational activity. If individuals could not use such substances at work, they could use them during their private time, at sporting events, concerts, dances, and dinner, in bars, restaurants, and automobiles, in short, *anywhere but at work*. For at least a moment, symbolically and physically, they were able to experience the feelings of empowerment, personal control, self-expression. For many, a comparable experience was not available through any other endeavor; also, no other endeavor was equally well advertised.

In most leisure activities, from sports to music, but also in love and sex—all "nonproductive" functions—there were obvious links to the use of alcohol and other drugs. The importance of this culture of substance use, together with the economic impact of its legitimate (and illegitimate) promotion cannot be overemphasized. Alcohol and cigarette companies came to underwrite everything from sports to theater; over $700 million is spent in advertising over-the-counter drugs (primarily headache and painkilling medication). Men and women today rely heavily on mind-altering substances to balance their days because this is what they have been told to do for over nine decades.

Many Americans know that "weekends are made for Michelob," that "Miller Time" occurs at the end of the day, and for many college students, their most heated debate may be over whether light beer "tastes great" or is "less filling." This is the successful legacy of seventy-five years of recreational advertising of alcohol. Whether it is alcohol or cannabis, cocaine or heroin, the primary goal is leisure; to relax, escape, be free, at any cost.

American leisure is tied to the purchase of goods that are intended to aid, augment, and ease an escape from the strict controls of work. For many, that escape is represented and reinforced by the use of

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various substances, bought at the closest distribution point: the pharmacy, the bar, or the street corner.

## CONCLUSION

The creation of a consumer culture whose values reinforce personal freedom—a desire for individual liberty and the escape from authority—at the same time emphasizing social responsibility, rationality, productivity, and efficiency, cannot be ignored in the current drug-policy debates.

Alcohol and other drug use in the United States, but also in other industrial societies, provides contradictory and conflicting sets of meanings. On the one hand, recreational use is meaningful as a cue to nonwork, release, leisure time. On the other hand, to use alcohol and other drugs to certain limits is to jeopardize one's health, to trespass certain accepted social bounds. Lacking the traditional constraints once imposed by community, religion, production, and ritual, the freedom to consume, to escape the controls of work, may lead to the introduction of new forms of social control, sometimes entering one's so-called private and free time. This may occur not only through the introduction of highly restrictive laws but also in the creation of additional moral imperatives linked to purity, health, and success.

For many in contemporary American culture, the use of alcohol and/or other drugs has offered a clear delineation between work and leisure, between "their time" and "my time." Drugs are used while engaging in leisure activities and may well become a leisure activity in themselves. Alcohol and other drugs provide, in a relatively simple way, the freedom, self-discovery, and release that leisure is supposed to represent. It is this century-old "new" definition that underlies the issue of drug use. What are the appropriate limits of alcohol and other drug use if work is the only limiting factor?

If our cultural ideology reinforces the belief that we are free to consume anything we want or are in a position to purchase, why should we limit our freedom to consume alcohol and other drugs? If we are constantly told that to strive towards freedom is a worthy goal, why are limits imposed to our freedom to alter our perceptions and moods? Are the only legitimate limits those that reduce our potential to be efficient and productive in the workplace? Or, is it legitimate to restrict use because the substances may harm our

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health? But what if work itself limits creativity and is itself a hazard to health? And what is one to say if there is no work? Would not the use of certain substances provide men and women with limited income the images, emotive states, and experience of freedom in many ways comparable to what others experience in going off on vacation or buying some other leisure commodities?

The language of prohibition in regard to currently illicit drugs, and the vocabularies of moderation and responsible use with regard to alcohol, express cultural beliefs developed over a century ago. Through the continued use of terms that symbolically communicate a belief in the "new industrial order," we continue to reinforce what leads to excessive use in the first place. To be "moderate" in the face of continued pressure to increase productivity and efficiency is simply inconsistent. When this is joined to a perpetual celebration of leisure and freedom, there is a need to reassess the meanings such substances hold in our culture. The creation of further prohibitions and the enforcement of stricter penalties—like the limiting of accessibility to particular substances of choice—only conceals the complex situations of today, which no longer accepts productivity, efficiency, and strict rationality, all linked to industrial production and the factory, as the preeminent values. Will we continue to direct our energies toward such ideals when they may in fact be promoting the very tensions that many are today seeking to escape? Or will we begin to ask wholly new questions about human needs?

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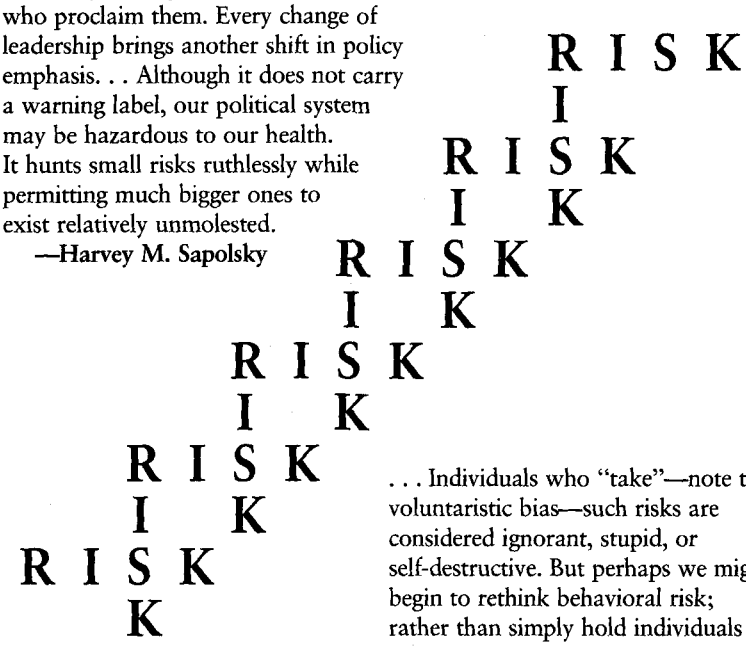
. . . We are told that the fight to control AIDS is our number-one priority, but so are the control of cigarette smoking, drunk driving, drug abuse, and teenage pregnancy. If priorities are always changing, so too are the officials who proclaim them. Every change of leadership brings another shift in policy emphasis. . . Although it does not carry a warning label, our political system may be hazardous to our health. It hunts small risks ruthlessly while permitting much bigger ones to exist relatively unmolested.

—Harvey M. Sapolsky




. . . Individuals who "take"—note the voluntaristic bias—such risks are considered ignorant, stupid, or self-destructive. But perhaps we might begin to rethink behavioral risk; rather than simply hold individuals accountable for the risks they incur, we might ask who is at risk to become, or remain, a cigarette smoker and why.

—Allan M. Brandt

The 1980s attack on the welfare state was a tale of a tub. Safety nets for the poor, as for the rich, posed no serious threat to American character, family ties or the work ethic.

—Theodore J. Lowi

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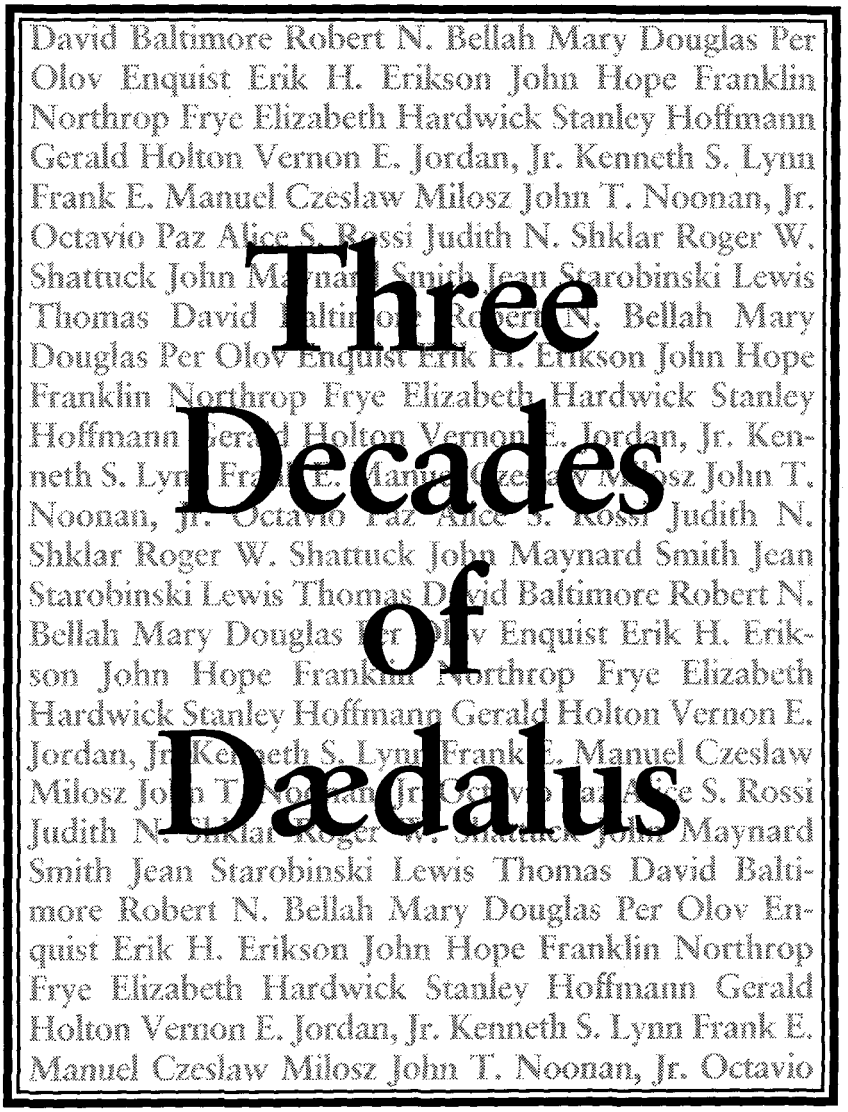


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